

## *Medical Release Form*

Parent/Legal Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #s: Home (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Other (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Children's Names	List all Known Medical Conditions, Including Food Allergies and/or Drug Allergies. In Addition, Include Any and All Over-the-Counter and/or Prescription Drugs Taken Regularly.

In an emergency, please contact: \_\_\_\_\_

Relationship to child/children: \_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Or contact: \_\_\_\_\_

Relationship to child/children: \_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Billing Address: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to child/children: \_\_\_\_\_

ID #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Phone #s: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Billing Address: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to child/children: \_\_\_\_\_

ID #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

**Statement of Consent:** *(To be signed in the presence of a legalized notary public.)*

*In the event of an emergency or non-emergency situation requiring medical treatment, I, \_\_\_\_\_, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notarization:**

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(date) (month) (year) (name of parent)

personally appeared before me in \_\_\_\_\_ County (in the state of \_\_\_\_\_)

and, in my presence, signed this medical release form.

Name of Notary Official: \_\_\_\_\_

Signature: \_\_\_\_\_

Commission Expires: \_\_\_\_\_