MEDICAL RELEASE FORM

In case of emergency, please accept this letter as authority to treat my child whose name(s) is (are) listed below.

Child's Name Birth date Age Allergies

_____

_____

_____

_____

Physician _____ Phone _____

Address _____

Name of Insurance _____ Group # _____

_____

Mother or Guardian's Name Cell Phone #

_____

Father or Guardian's Name Cell Phone #

_____

Home Address Home Phone #

_____

Emergency Contact/Relationship Phone #

If you are unable to contact our physician, please accept this letter as your authority to use the doctor on call in the emergency room for any emergency medical treatment.

_____

Parent or Guardian Signature Date