MEDICAL RELEASE FORM

As the parent/legal guardian of________________________________. I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above-named minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

______________________________ ______________________________

Date of Birth **Date of last Tetanus Booster**

____

Known Allergies - including but not limited to medicine, food, etc. (Continue on back of form if needed)

____

Medical issues which should be noted. (Continue on back of form if needed)

____

Name of Parent(s) / Legal Guardian(s) **Address** **City / State / Zip**

____

Telephone: **Home** **Work** **Mobile**

____

Person responsible for charges (If different from above) **Address** **City / State / Zip**

____

Telephone: **Home** **Work** **Mobile**

____

Person to notify if parent/guardian is unavailable **Home Phone** **Work** **Mobile**

____

Family Physician **Telephone**

____

Insurance Carrier and Policy Number

______________________________ ______________________________

Parent / Guardian Signature **Date**

______________________________ ______________________________

Parent / Guardian Signature **Date**