NEW STUDENTS
7.4

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**