



MEDICAL TREATMENT RELEASE FORM

As a parent/guardian, I do hereby authorize first aid/medical treatment of my child in the event of an emergency which may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. It is understood that efforts will be made to reach me as soon as reasonably possible.

Name of child: _____ Relationship to you: _____

Reason for which release is intended: _____

Address of Child: _____

Daytime Phone: _____ Emergency Phone: _____

Family Physician: _____ Office Phone: _____

Office Address: _____

List allergies, medication, dietary restrictions, contact, or other pertinent comments:

Health Insurance Data:

Company: _____ Policy Number: _____

Group Number: _____ Contract: _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstance in my absence.

I certify that I am the (check one) _____ custodial parent _____ legal guardian of the minor child named above, and I agree to the above terms for myself and for my minor child.

Date: _____

Signed: _____
(Parent or Guardian)

State of _____

Subscribed and sworn to before me

County of _____

this _____ day of _____ 20____

Notary Public