

# Medical Release Form

Date form completed:	Revised:	Initials:
By whom:	Revised:	Initials:

I, \_\_\_\_\_, (parent/guardian's name) hereby give permission for any and all medical attention to be administered to my child, \_\_\_\_\_, (child's name) in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

<b>Name:</b>	
<b>Home address:</b>	<b>Home/Cell phone:</b>
<b>Work phone:</b>	<b>Insurance company:</b>
<b>Policy number:</b>	
<b>In case I cannot be reached, any of the following people may act on my behalf:</b>	
<b>Contact 1:</b>	<b>Phone:</b>
<b>Contact 2:</b>	<b>Phone:</b>
<b>Contact 3:</b>	<b>Phone:</b>
<b>Contact 4:</b>	<b>Phone:</b>
<b>Physician:</b>	<b>Phone:</b>
<b>Address:</b>	
<b>Known allergies:</b>	
<b>Special instructions:</b>	
<b>Signature of parent/guardian:</b>	<b>Date:</b>

<b>Subscribed and sworn before me, this _____ day of _____, 20_____.</b>
<b>Notary public:</b>