SCSA Medical Release Form

As the parent or legal guardian of _____,
I request that in my absence, the above-named minor may 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 authorized the hospital or medical facility to dispose of any specimen or tissue taken from the above named minor.

Date of Birth: _____/ _____/ _____ (month / day / year)

Date of last Tetanus Booster: _____/ _____/ _____ (month / day / year)

Known allergies of this minor, including any allergies to medicine:_____

Any other medical problems which should be noted**:** _____

Family Physician: _____ Phone: (_____) _____

Name of Parent / Guardian: _____
Address: _____
City, State, Zip: _____
Phone: _____ Work: _____

Person responsible for charges (*if different from above*): _____
Address: _____
City, State, Zip: _____
Phone: _____ Work: _____

Person to notify if Parent / Guardian is unavailable: _____
Phone: _____ Work: _____

Insurance Carrier: _____ Policy Number: _____

_____

Signature of Parent or Guardian