

MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above-named Minor Child 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 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 Child.

Date of Minor Child's Birth ____/____/____ Date of last Tetanus Booster ____/____/____
Month Day Year Month Day Year

Known allergies of this Minor Child, including any allergies to medicine. Any other medical problems which should be noted

Family Physician - Phone _____

Parent/Guardian

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers (Home): _____

(Work): _____

(Work FAX): _____

Person responsible for charges

(if different from above)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers (Home): _____

(Work): _____

(Work FAX): _____

Person to notify if parent/guardian is unavailable

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers (Home): _____

(Work): _____

(Work FAX): _____

Insurance Carrier

Policy Number _____

Signature of Parent/Guardian _____

[NOTARIZATION]

STATE OF))

))

COUNTY OF))

Sworn to and subscribed before me on the day of _____

Notary Public in and for the State of _____

My Commission expires _____