

MEDICAL RELEASE

Child's Name _____ **Date of Birth** _____

In case of emergency, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, E.R. Physician).

Parent's Name (Please Print) _____

Parent's Signature _____

Date _____

MEDICAL INFORMATION

Family Physician: _____

Physician Phone: _____

Address: _____

Medical Ins.Group Name _____

Group No. _____

Subscriber Name _____ Subscriber No. _____

In case of emergency contact:

Name	Phone	Relationship to child
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_____	_____	_____
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Please list any allergies/medical problems, including those requiring maintenance medication (i.e. diabetes, asthma, seizure disorder),

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.