Medical Release Form

Parent/Legal Guardian's Name: _____

Address: _____

Phone #s: Home (_____) _____ - _____ Work (_____) _____ - _____

Cell (_____) _____ - _____ Other (_____) _____ - _____

Children's Names	List all known medical conditions, including food allergies and/or drug allergies. In addition, include any and all over-the-counter and/or prescription drugs taken regularly.

Emergency Contact: _____ Relationship: _____

Phone #s: (_____) _____ - _____ (_____) _____ - _____

(_____) _____ - _____ (_____) _____ - _____

Physician: _____ Phone #: (_____) _____ - _____

Address: _____

Primary Insurance: _____ Policy Holder: _____

ID #: _____ Group/Policy #: _____

Phone #: (_____) _____ - _____

Statement of Consent:

In the event of a situation requiring medical treatment, I _____, grant permission for any and all medical attention to be administered to my child/children until I can be contacted. This includes but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia under the recommendation of qualified medical personnel.

Signature: _____ Date: _____