

# Medical Release Form

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 even of accident, injury, sickness, etc. under to direction of the person(s) listed below. 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.

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

***I can be reached at:***

HOME: \_\_\_\_\_

WORK: \_\_\_\_\_

CELL: \_\_\_\_\_

OTHER PARENT: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

SIGNATURE (PARENT/GUARDIAN): \_\_\_\_\_

DATE: \_\_\_\_\_

Subscribed and sworn before me \_\_\_\_\_ day of \_\_\_\_\_

Witness: \_\_\_\_\_