

MEDICAL RELEASE FORM

This is a medical release for a Minor child, which may permit treatment in an emergency. While there are other methods for hospitals and other medical facilities to obtain permission to treat a minor child in the absence of parental consent.

I, _____, Parent or Legal Guardian of _____, a minor child, hereby authorize any Medical or Surgical treatment that may be necessary in an emergency, and in my absence, for the well being of the above mentioned minor. I agree to hold the physician or hospital treating the above mentioned minor harmless. I also give the hospital permission to release information to my insurance company(s) and give them permission to collect payment from said insurance company(s).

Allergies: _____

Medication currently taking: _____

Regular Physician: _____ Phone No. _____

Home Address: _____ Home Phone: _____

Father's Name: _____ Social Security Number: _____

Employer: _____ Work Phone: _____

Insurance Co: _____ ID number: _____

Mother's Name: _____ Social Security Number: _____

Employer: _____ Work Phone: _____

Insurance Co: _____ ID number: _____

Name of person other than guardian to contact in case of an emergency:

Relationship: _____

Address: _____ Phone: _____

Date: _____

Signature of Parent/Legal Guardian _____