Medical Release Form For Minor

Child's Information

Name: _____ Date of Birth: _____
Address: _____
Religion: _____
City: _____ State: _____ Zip Code: _____ Phone Number: _____

Medical Insurance Information

Name of Insurance Company: _____
Policy Number: _____
Group Number: _____
Primary Care Physician: _____
Phone Number: _____

Medical History

Allergies _____ Blood Type _____ Date of Last Tetanus Shot _____

Previous Hospitalizations and Major Illnesses _____
Current Medications _____
Pediatrician _____ Telephone _____ Other Important Information _____

Authorization for Medical Treatment

In case of an emergency, I authorize the designated caregiver, _____ ,to consent to and authorize any medical care or treatment deemed necessary for my child, _____ . This authorization includes the administration of medication and the authorization of any emergency medical treatment or procedures that may be required.

Medical Information

I hereby authorize any physician, hospital, or medical personnel to release any medical information or records regarding my child to the designated caregiver.

Contact Information

In case of an emergency, the designated caregiver is authorized to contact the following individuals:

Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____
Name: _____ Relationship: _____ Phone Number: _____

I hereby certify that I am the legal parent or guardian of the above-named child and that I have read and fully understand the terms of this Medical Release Form for Minor.

Parent or Legal Guardian Signature: _____

Date Signed: _____