



MEDICAL RELEASE FORM FOR MINOR CHILD

As the parent/legal guardian of _____, I request that in my
(PRINT CHILD'S FULL NAME)

absence the above-named person be admitted to any hospital or medical facility for diagnosis and treatment. I request and fully authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I completely authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named person.

Date of Birth: _____ Date of last Tetanus Booster: _____

Known allergies including any allergies to medicine: _____

Current medical conditions being treated for:

Medications currently taking and the dosage amounts: _____ -

Past medical conditions. Past surgeries?

Family Physician: _____,

Address: _____ **Phone:** _____

Include any other doctors currently treating your child:

Doctor: _____ **Phone:** _____

Address: _____

Name of Parent/Guardian: _____

Address: _____ **Phone** H _____ W _____

Cell _____, **Other** _____

Person to notify if parent/guardian is unavailable: Name/Address/phone also relationship to child?

_____ **Phone(S):** _____

Person responsible for charges (if different from above) Parents

Address _____ Phone H _____ W _____

Insurance Carrier _____ Policy Number _____

SIGNATURE of Parent/Guardian _____ Date _____

PRINT NAME OF PARENT(S): _____

WITNESS _____ Date: _____