MEDICAL RELEASE FORM

As the parent/legal guardian of _____ , I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and 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 authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

Date of Birth Date of last Tetanus Booster

Known allergies including any allergies to medicine (Continue on back of form if needed)

Any other medical problems which should be noted (Continue on back of form if needed)

Name of Parent/Guardian

Address City/State/Zip

Phone Home Work Mobile

Person responsible for charges (if different from above)

Address City/State/Zip

Phone Home Work Mobile

Person to notify if parent/guardian is unavailable

Phone Home Work Mobile

Family Physician Phone

Insurance Carrier & Policy Number

Signature of Parent Date

Signature of Witness Date