MEDICAL RELEASE FORM FOR A MINOR

Minor #1: Name _____ **Date of Birth** _____

Minor #2: Name _____ **Date of Birth** _____

Minor #3: Name _____ **Date of Birth** _____

Parent/Guardian's Name _____

Home Address _____ **City**_____ **State**_____

Zip_____ **Home Phone** _____ **Cell Phone** _____

Employer _____ **Work Phone** _____

Insurance Provider _____ **Policy #** _____

Address _____

Notify in Emergency (if other than parent or guardian) _____

Relationship _____ **Phone** _____

Family Physician _____ **Phone** _____

Allergies _____ **Last Tetanus** _____/_____/____

Medicines currently being used Dosage/ Frequency_____ _____

Current overall health _____

AUTHORIZATION FOR TREATMENT OF MINORS

We, the undersigned, parent or legal guardian of these minors:

1. _____

2. _____

3. _____

do hereby consent authorized medical personnel to perform routine tests and treatment for the health of my children. In the event that we cannot be reached in an emergency, we hereby give permission for an authorized physician to hospitalize, secure proper treatments, and to order injection, anesthesia, or surgery for my children as named above.

_____
(Parent/ Guardian Signature & Date)