Medical Release

Child's Name: _____ Gender: _____ DOB: _____

Grade in School (rising grade if school is out): _____ Referring Organization: _____

Emergency Contact Name: _____ Phone #: _____

Home Address: _____

Medical Information

Primary Care Physician's Name: _____ Phone #: (_____)_____

Medical Insurance Provider: _____ Policy #: _____

Allergies to medications/foods/ other allergies:

_____

Medical Conditions for which the minor is receiving treatment:

_____

Prescription drugs the minor is taking:

_____

Other pertinent medical information such as activity restrictions:

_____

AUTHORIZATION AND CONSENT OF PARENT OR LEGAL GUARDIAN: As custodian of the aforementioned minor, I grant my authorization and consent for a designated adult to administer general first aid treatment for minor injuries or illnesses. If the injury or illness is severe, I authorize him or her to seek professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical care deemed advisable by a licensed medical professional or institution. I authorize the designated adult to exercise best judgment upon the advice of medical or emergency personnel.

Parent/Guardian Signature: _____Date: _____

Printed Name: _____ Contact #: _____