

Medical Release Form

Please complete all of the following information:

Name: _____
Last First Middle DOB

Address: _____
Street City State Zip

Telephone: () _____

Notify in Case of Emergency:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Telephone: () _____ Telephone: () _____

Cell Phone: () _____ Cell Phone: () _____

Allergies to medications, foods, etc...? _____

Any History of Serious Illness, Recent Hospitalizations or Injuries? _____

Medications currently being taken? _____

In the event _____ suffers any illness or accident requiring hospitalization, medical treatment or medication, I hereby give my permission for any medical treatment which may be deemed necessary and responsible under the circumstances.

Parent's or Guardian's signature

Date

Health Insurance Company: _____

Policy Number: _____

Group Number: _____