Medical Release Form for Minor

CHILD'S INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Address:

Religion: _____ City: _____

State: _____ Zip Code: _____

Phone Number: _____

MEDICAL INSURANCE INFORMATION

Name of Insurance Company: _____ Policy Number: _____

Group Number: _____ Primary Care Physician: _____

Phone Number: _____

MEDICAL HISTORY

Allergies:

Blood Type: _____ Date of Last Tetanus Shot: _____ dd / mm / yyyy

Previous Hospitalizations and Major Illnesses:

Current Medications:

Pediatrician: _____ Telephone: _____

Other Important Information:

AUTHORIZATION FOR MEDICAL TREATMENT

In case of an emergency, I authorize the designated caregiver,[Name], to consent to and authorize any medical care or treatment deemed necessary for my child, [Name]. This authorization includes the administration of medication and the authorization of any emergency medical treatment or procedures that may be required.

I hereby authorize any physician, hospital, or medical personnel to release any medical information or records regarding my child to the designated caregiver.

CONTACT INFORMATION

In case of an emergency, the designated caregiver is authorized to contact the following individuals:

Emergency Contact 1 - Name: _____ **Emergency Contact 1 - Relationship:** _____

Emergency Contact 1 - Phone Number: _____ **Emergency Contact 2 - Name:** _____

Emergency Contact 2 - Relationship: _____ **Emergency Contact 2 - Phone Number:** _____

Emergency Contact 3 - Name: _____ **Emergency Contact 3 - Relationship:** _____

Emergency Contact 3 - Phone Number: _____

I hereby certify that I am the legal parent or guardian of the above-named child and that I have read and fully understand the terms of this Medical Release Form for Minor.

Parent or Legal Guardian Signature:

Date Signed: _____ dd / mm / yyyy