Medical Release Form for Minors

CHILD'S INFORMATION

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

Religion: _____ Address: _____

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 or major illnesses:

Current medications:

Pediatrician: _____ Phone number: _____

Other important information:

AUTHORIZATION FOR MEDICAL TREATMENT

Authorization is as follows:

MEDICAL INFORMATION

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(s):

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 release form.

Parent or legal guardian signature:

Date: _____ dd / mm / yyyy