Medical Release Form

I hereby give permission for any and all medical attention necessary to be administered to my child (*name*)_ in the event of accident, injury, sickness, etc., under the direction of either of the person(s) designated below, until such time as I may be contacted. If neither person(s) designated below can be contacted, I give my permission for treatment of my child as may be required subsequent to a determination made by the appropriate health care professional who is present. This release is effective until revoked, in writing, by me. I also hereby assume responsibility for payment of such treatment.

Please Print:
My Name: _

My Address: _
(Street) *(City)* *(State)* *(Zip)*
Home Phone: _ Work Phone: _

Cell Phone: _

My Insurance Company: _

My Insurance Policy #:_

In the case I cannot be reached, please contact the following individuals:

Name: Phone:

Name: Phone:

My Physician: _ Phone: _
Physician's Address: _
Known Allergies of Child:

Parent's Signature: _____ Date: _____