

MEDICAL RELEASE FORM

I, _____, parent or guardian of _____, authorize the bearer of this document to obtain all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. I also accept full responsibility for the payment of any expenses incurred from such medical and/or emergency care.

Parent/Guardian Signature

Date

Home Phone

Cell Phone

Email Address

Alternate Contact: _____ Phone number: _____

Name of family physician: _____ Phone number: _____

Name of Insurance Company: _____ Policy or Group#: _____

Current medication, allergies or health problems: _____

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