



Medical Release Form

In case of emergency, please accept this letter as authority to treat my child whose name(s) is(are) listed below:

Child's Name	Birthdate	Age	Allergies

Physician _____ Phone _____

Address _____

Name of Insurance _____ Group # _____

Primary Insured Name _____ Birthdate _____

Mother's Name _____ Cell Phone # _____

Father's Name _____ Cell Phone # _____

Home Address _____

Home Phone # _____

Emergency Contact/Relationship _____ Phone # _____

If you are unable to contact our physician, please accept this letter as your authority to use the doctor on call in the emergency room for any necessary emergency medical treatment.

Parent's Signature _____ Date _____