

# MEDICAL RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Names of ALL children in program \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Reason for which release is intended: \_\_\_\_\_

Address of Minor: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Phone(s): \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone: \_\_\_\_\_

List allergies, medication, contract or other pertinent comments. Please specify each child.

\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Data:

Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician. I acknowledge that it is my responsibility to submit a new form if any of the above information changes.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

(Parent or Guardian)

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**Office Use Only**

## RECORDED CORE TOPICS

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_