EMERGENCY MEDICAL RELEASE

I, _____, of _____am the
Parent/Guardian Full Name Address

_____ of _____ a minor, of _____
Parent/Guardian Child's Name Address

I hereby give my consent, in the event that all reasonable attempts to contact me at _____
Phone

or _____at _____ have been unsuccessful, for:
Other Parent/Guardian Phone

1) The administration of any treatment deemed necessary by Dr. _____, _____
Preferred Physician Phone

Or _____ , _____ or, in the event that the appropriate preferred
Preferred Dentist Phone

practitioner is not available, by a licensed physician or dentist and

2) The transfer of the child to _____ or any hospital reasonably accessible.

The child is covered under the following Medical Insurance Company:

_____ Policy # _____

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concur in the necessity of such surgery. The following is needed by any hospital or practitioner not having access to the child's medical history:

Allergies: _____ Medication being taken: _____

Date of last tetanus shot:_____ Physical impairments (Heart, epilepsy, etc.,): _____

_____ Other pertinent facts to which a physician should be alerted: _____

_____

_____

Parent/Guardian's Signature: _____ Date: _____