MEDICAL RELEASE

Last Name _____ First Name _____ Middle Initial _____ Date of Birth *(mm/dd/yyyy)* _____

Home Address _____ City _____ State _____ ZIP Code _____

Parent / Legal Guardian Contact Information:

(_____) _____ - _____ Daytime Phone

(_____) _____ - _____ Home Phone

(_____) _____ - _____ Cell Phone

Emergency Contact Information:

_____ _____ (_____) _____ - _____
Name of Emergency Contact Relationship Phone

_____ _____ (_____) _____ - _____
Name of Emergency Contact Relationship Phone

_____ (_____) _____ - _____
Name of Family Physician Phone

Medical Information: (*Child's physical or emotional health conditions that the clinician should be aware of.)*
Allergies

Recurring illnesses, disabilities, chronic illnesses etc.

Medications

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I cannot be reached, I give my consent for a licensed practitioners of the healing arts to perform any necessary emergency treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I am responsible to submit any claims to my health insurance company for reimbursement.

_____ _____
Parent / Legal Guardian Name *(please print)* Signature

_____ _____
Parent / Legal Guardian Health Insurance Company Policy Subscriber's Name

_____ _____
Policy Number Group Number