

## MEDICAL RELEASE FORM FOR MINOR

Minor's Name	
Address	
Date of Birth	Gender <input type="checkbox"/> Female <input type="checkbox"/> Man

### Medical Information

Primary Care Physician's Name	
Phone	
Medical Insurance Provider	Policy #
Allergies to Medications	

Medical Conditions for which the minor is receiving treatment	
Prescription Drugs The Minor Is Taking	Other Pertinent Medical Information

**AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)** As custodian of the aforementioned minor, I grant my authorization and consent for a designated adult to administer general first aid treatment for minor injuries or illnesses.

If the injury or illness is severe, I authorize him or her to seek professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical care deemed advisable by a licensed medical professional or institution. I authorize the designated adult to exercise best judgment upon the advice of medical or emergency personnel.

Effective Date
Signed This            day of            ,20
Printed Name

Parent / Guardian Signature