

# Medical Release Form

Minor's Name:

Home Address:

Date of Birth:  Gender:

## 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

Parent / Guardian Signature:

Printed Name: