Medical Treatment Release Form

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor:_____ **Relationship to you:** _____

Reason for which release is intended: _____

Address of Minor: _____ _____

Phone:_____ **Emergency Phone:**_____

Family Physician:_____ **Phone:** _____

Physician Address: _____**City:** _____

List allergies, medications, contract, or other pertinent comments: _____

_____

_____

_____

Health Insurance Data:

Company: _____ **Policy:**_____

Group:_____ **Contract:** _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date: _____ **Signed:** _____
(Parent or Guardian)