



Medical Release

I hereby give my permission for any and all medical attention necessary to be administered to my child, _____, in the event of an accident, injury, or sickness under the direction of the persons listed below, until such time as I may be contacted. This release is effective until revoked by me. I also hereby assume responsibility for payment of any such medical treatment.

My name: _____

Address _____

City/ State/ Zip: _____

Telephone (Home) _____

(Work) _____ (Cell) _____

Medical Insurance Company: _____

Policy Number: _____

In case I cannot be reached, any of the following is designated to act on my behalf:

1. _____ (Phone) _____

2. _____ (Phone) _____

3. _____ (Phone) _____

Our physician is: _____ (Phone) _____

Our Dentist is _____ (Phone) _____

List any allergies (including medication): _____

List any medication the child is taking: _____

Parent's signature: _____