# Medical Release Form

NAME: ______________________________________________________________
Last | First | Middle | DOB

ADDRESS: ___________________________________________________________
Street | City | State | Zip

TELEPHONE: (____) ____________________

**NOTIFY IN CASE OF EMERGENCY:**

NAME: ________________________________ NAME: ________________________________

RELATIONSHIP: __________________________ RELATIONSHIP: __________________________

ADDRESS: ______________________________ ADDRESS: ______________________________

______________________________________ ______________________________________

TELEPHONE: (____) ____________________ TELEPHONE: (____) ____________________

IF NO ANSWER: (____) __________________ IF NO ANSWER: (____) __________________

ALLERGIES TO MEDICATIONS, FOODS, ETC.? ____________________________________

_______________________________________________________________________

WHAT MEDICATIONS ARE CURRENTLY BEING TAKEN? ______________________________

_______________________________________________________________________

DATE OF LAST TETANUS SHOT: _______________________________________________

NAME OF FAMILY PHYSICIAN: ______________________________ PHONE: (____)__________________

In the event ______________________________ suffers an illness or injury requiring hospitalization, medical treatment, or medication, I hereby give my permission for any medical treatment which may be deemed necessary by medical personnel.

______________________________________ ______________________________
Parent's or Guardian's Signature Date

HEALTH INSURANCE CO.: ____________________________________________________

POLICY #: ______________________________________________________________

GROUP NUMBER: __________________________________________________________