



Medical Release Form/Consent to Treat a Minor

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as emergency medical, dental, surgical care or hospitalization becomes necessary.

| |
|---|
| <p>1. Name of Minor _____</p> <p>Birth Date: _____</p> <p>2. Name of Minor _____</p> <p>Birth Date: _____</p> <p>Name of Parent or Guardian: _____ Home Phone: _____</p> <p>Street Address: _____ Work Phone: _____</p> <p>City, State, Zip: _____ Cell Phone: _____</p> <p>Name of Alternate Contact Person _____ Phone: _____</p> |
|---|

| |
|---|
| <p>Please record any allergies or current health conditions requiring medical treatment, medications or special restrictions (continue on back if necessary) on any Minor(s) listed above.</p> <p>_____</p> <p>_____</p> |
|---|

| |
|---|
| <p>* Name of Insurance Company for Minor(s): _____</p> <p>Identification Number(s): _____</p> <p>Phone Number of Insurance Company: _____</p> <p><i>* Please include a copy of Medical Insurance Card (Front and Back).</i></p> |
|---|

| |
|--|
| <p>Family Physician: _____ Phone Number: _____</p> <p>Date of last tetanus shot: _____</p> |
|--|