Medical Release Form

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Authorization

 For Medical Treatment of Minors

|  |  |  |
| --- | --- | --- |
| **Names of Minors** | **Birthdates** | **Special Conditions** |
|  |  |  |
|  |  |  |

**I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Address** | **Phone** |
|  |  |  |
|  |  |  |
|  |  |  |

**To act in my behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from:**

**\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Through \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

 **Month Day Year Month Day Year**

**This Document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required**

|  |  |
| --- | --- |
| **Parent/ Guardian** | **Parent/ Guardian** |
| **Signature Date**  | **Signature Date** |
| **Address** | **Address** |
| **Witness** | **Witness** |
| Signature Date | **Signature Date** |
| **Address** | Address |

-Continued on back-

**Hospitalization coverage for above named minor(s):**

|  |  |
| --- | --- |
| **Insurance company or Gov. Plan** | I.D. or Contract Number |

**Family Physicians:**

|  |  |
| --- | --- |
| **Name and Phone Number** | **Name and Phone Number** |