MEDICAL RELEASE FORM

I, _____, parent or guardian of _____ do authorize the bearer of this document to obtain any and all medical and/or emergency care, which in the bearer's opinion is needed by my child. I also accept full responsibility for the payment of any expenses incurred from such medical and/or emergency care.

_____ _____

Parent/Guardian Signature Date

Home Phone: _____ Work Phone: _____

Alternate Contact Name(s): _____

Alternate Contact Phone Number: _____

Name of Family Physician: _____

Physician's Phone Number: _____

Name of Insurance Company: _____

Policy or Group#: _____

Current Medication, Allergies or Health Problems:

_____

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