MEDICAL RELEASE FORM

2024 SSOT Florida YP

Child 1: ________________________ Birth date: ___/___/___ Grade in Fall '22: ______

Child 2: ________________________ Birth date: ___/___/___ Grade in Fall '22: ______

Child 3: ________________________ Birth date: ___/___/___ Grade in Fall '22: ______

I, ________________________, parent or guardian of the above named child(ren), 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(ren). I also accept full responsibility for the payment of any expenses incurred from such medical and/or emergency care.

______________________________ ________/________/_______

Parent/Guardian Signature Date

______________________________ ______________________________

Primary Phone Alternate Phone

Alternate Contact: ____________________________ Phone Number: ____________________

Name of Family Physician: ____________________ Phone Number: ____________________

Name of Insurance Company: ___________________ Policy or Group #: _________________

Current Medication, Allergies or Health Problems:

Child 1: ____

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Child 2: ____

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Child 3: ____

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