

# MEDICAL RELEASE FOR MINOR CHILD

I, \_\_\_\_\_, Parent or Legal Guardian of \_\_\_\_\_,

a minor child, hereby authorize any Medical or Surgical treatment which may be necessary in an emergency, and in my absence, for the well being of the above mentioned minor. I agree to hold the physician or hospital treating the above mentioned minor, harmless.

Address and contact information:

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The above mentioned minor has the following allergies or Medical conditions:

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Insurance Information:

Name of Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Signature of Parent \_\_\_\_\_

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