

MEDICAL RELEASE FORM

Child's Name: _____

Child's Age: _____ Date of Birth: _____

Known Allergies _____

Doctor: _____ Phone: _____

Parent Name: _____ Phone: _____ W: _____

If for any reason I am not able to be contacted, I hereby give authorization to _____
Hospital to administer any medical treatment or emergency care to my child _____

I also understand if the physician listed above is not available for any reason that an on-staff physician
will have my permission to treat my child during an emergency situation.

Date: _____

Parent or Guardian Signature: _____