

MEDICAL RELEASE FORM

I, _____ hereby give permission for any dental/medical attention
(Parent/Guardian's Name)
to be administered to my child _____ in the event of accident,
(Child's Name)
injury, sickness, etc. under the direction of the person(s) listed below, until such time as
I may be contacted. I also assume the responsibility for the payment of any such
treatment. This release is effective for the period of one year from the date given below.

ADDRESS:

INSURANCE COMPANY: _____

POLICY NUMBER: _____

In case I cannot be reached, any of the following persons is designated to act on my behalf.

- Closest relative _____
- Friend _____
- Other _____

PHYSICIAN: _____

DENTIST: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES/MEDICATIONS _____

SIGNATURE (PARENT/GUARDIAN) _____ DATE _____