MEDICAL & DENTAL RELEASE FORM FOR MINOR

I, _____ certify that I am the parent or legal guardian of the minor listed below, and as such, I hereby convey authority to the adults designated below for the sole purpose of obtaining any emergency medical or dental care for my minor that is recommended by a licensed healthcare provider to whom the minor is presented for treatment subject to the limitations provided below (if any) and as may be deemed necessary for the well-being of my minor when not accompanied by a parent/legal guardian, or should either parent/legal guardian be unreachable by telephone.

BE IT FURTHER KNOWN THAT I hereby releases any licensed health care provider providing medical care to the minor listed below in reliance of this form from liability relating to such provider's acceptance of my substitute care giver's consent.

THEREFORE, I hereby approve and empower the individuals listed below with the authority to arrange and/or consent to any and all emergency medical or dental care treatment of my minor in my absence. This consent shall remain in effect until it is revoked by notifying the appropriate medical, mental healthcare and insurance providers, in writing, as well as the agent(s) named below that I wish to revoke it.

_____ _____

(Signature of Parent/Legal Guardian) (Date)

_____ _____

(Name of Parent/Legal Guardian) (Relationship to)

_____ _____

(Home/Work Number) (Email Address)

_____

(Cell Phone Number)

MINOR

Child's Name:
Address: , ,
Telephone Number:
Date of Birth:
Parent/Legal Guardian:
Address: , ,
Home/Work Telephone:
Cell Telephone:
Email Address:
Allergies:
Medical Conditions:
Current Medications:

PRIMARY CHILD CARE PROVIDER

-

(Primary Child Care Provider Name)

(Relationship to Minor Child)

(Home/Work Telephone Number)

(Email Address)

(Cell Phone Number)

AUTHORIZED EMERGENCY CONTACTS

(Emergency Contact Name)

(Relationship to Minor Child)

(Home/Work Telephone Number)

(Email Address)

(Cell Phone Number)

HEALTH INSURANCE & DOCTOR INFORMATION

Insurance Company:

Policy Number:

Group Number:

Physician's Name:

Address: , ,

Telephone Number:

Email Address:
