Medical Release Form

As the parent/legal guardian of _________________________, I request that in my absence the above-named student be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named student.

Student's Date of Birth____/_____/_____ Date of last Tetanus Booster_____/_____

Known allergies of the student, including allergies to medicine__________________________________

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Any other medical problems which should be noted____

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Family Physician:_____________________________________ Phone:___________________________

Name of Parents/Guardians:____

Father:____ Phone:___________________________

Mother:____ Phone:___________________________

Address____

City/State/Zip____

Person to notify if parent/guardian is unavailable____

Relationship to student________________________________ Phone:___________________________

Insurance Carrier:_____________________________________Policy #:_________________________

Known allergies:________________________________ Seizure disorders:_________________________

Heart condition:________________________________ Diabetes:_________________________________

Physical limitations:____

Medications:____

Parent Signatures:____ Date:__________________