MEDICAL RELEASE FORM

Parent Consent for Medical Treatment

NAME:______________________________ ____________________________ _______ BIRTHDATE:___________

Last First M.I.

ADDRESS:____________________________________ __________________________ MN ____________________

Street & Number City Zip

PARENT/GUARDIAN:____

PHONE HOME: ___________________ WORK: ____________________ CELL: ____________________

PARENT/GUARDIAN:____

PHONE HOME: ___________________ WORK: ____________________ CELL: ___________________

1. ALLERGIES to food, medications, etc. (If none, state it so)

____

____

2. SPECIAL MEDICAL PROBLEMS: (If none, state it so)

____

____

3. Does participant carry or require MEDICATION? (If none, state it so)

Medication________________________ Dose_________________ Purpose_______________________

Medication________________________ Dose_________________ Purpose_______________________

4. Does participant have permission to take any of the following if needed (please check if so):

_____ TYLENOL _____ IBUPROFEN _____ BENADRYL _____ TUMS

5. Any specific ACTIVITIES to be ENCOURAGED: ____

RESTRICTED: ____

6. SPECIAL DIET?____

7. Date of last TETANUS SHOT: ____

8. Family PHYSICIAN: _______________________________ CLINIC: _______________________________

ADDRESS: ____________________________ ___________________ MN __________________

Street & Number City Zip

Phone Number: _____________________________________

9. INSURANCE Company: ____

ID Number: _____________________ Group Number: ______________ Dept# ___________

I, the undersigned, being the parent, legal maid-of-kin, or legal guardian of _________________________ here-by authorize any necessary medical treatment for this person for 18 months from the date signed. I also guarantee payment of all charges incurred during the course of said medical treatment (physician, hospital, X-ray, lab, medication, ambulance, etc.)

PARENT/GUARDIAN SIGNATURE: ____ Date: ___________

PRINT NAME: ________________________________ RELATIONSHIP: __________________________________