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: _____