

Medical Release Form

Name of youth: _____ Birth date: _____

Address: _____

Name of parent or guardian: _____

Youth's physician: _____

Emergency contact: _____ Phone: _____

Emergency contact: _____ Phone: _____

Health History: Please circle all that apply.

- | | |
|-------------------------------------|-------------------------------|
| -frequent colds | -vision or hearing impairment |
| -sleep disturbances | -physical disability |
| -emotional or behavioral disability | -diabetes |
| -seizure disorders | -asthma |
| -stomach upsets | -motion sickness |
| -mental disability | -ADHD |

Other medical concerns to include any food or drug allergies:

Please list all medications prescription or non-prescription:

Can your son/daughter be expected to take the right amount of medication at the proper time?

Medical Release Form

I give my child permission to administer his/her own medications.

Signature of parent or guardian: _____ Date: _____

Name of insurance carrier: _____ Policy No: _____

Name of primary insured: _____

Other important insurance information: _____

(OVER)

Allergies including food give details

Please list all medications prescription or nonprescription:

Can your son/daughter be expected to take the right amount of medication at the proper time.

Medical release form

I give my child permission to administer his/her own medications.

Signature of parent or guardian _____ Date _____

Name of insurance carrier _____ Policy number _____

Name of primary insured _____

Other important insurance information

Statement of consent for treatment

I, the undersigned, parent/legal guardian of _____ do hereby consent to any x-ray, exam ,anesthetic, medical diagnosis or treatment and hospital services that may be rendered to said minor. Under the general or specific instruction of (name of physician) _____ or if unavailable the on-call physician of the hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment, and is given to encourage those persons who have temporary custody of my child. In my absence, and said physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment.

This consent will remain effective until _____ Delivered to persons entrusted with the care custody and control of said minor child. I understand that any and all medical expenses incurred are my responsibility.

Signature of parent or legal guardian

Date