

EMERGENCY TREATMENT RELEASE

As parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after reasonable effort has been made to reach me.

Name of minor _____ Birth date _____

Relationship (son or daughter) _____

Date or dates when release is intended _____

This release form is completed and signed on my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed _____ Date _____
(father/mother/legal guardian)

Name _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____

Another person responsible for my child in my absence:

Name _____ Phone _____

Relationship to child _____

Family Physician:

Name _____ Phone _____

Child's allergies _____

Chronic illnesses (asthma, diabetes, epilepsy, etc.) _____

Special information _____

Date of last tetanus booster _____