

FAMILY INFORMATION & MEDICAL RELEASE

child	child's name	birth date	allergies
#1			
#2			
#3			
#4			

parents	
address	

home phone	
mom work	
mom cell	
dad work	
dad cell	

child: #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> #4 <input type="checkbox"/>			
doctor		phone	
clinic name		address	
hospital			

child: #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> #4 <input type="checkbox"/>			
doctor		phone	
clinic name		address	
hospital			

child: #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> #4 <input type="checkbox"/>			
dentist		phone	
		address	

In case of emergency, other than parent		
name	relationship	phone

In the event that reasonable attempts to contact the parents, named above, have been unsuccessful, I hear by give my consent for the administration of any treatment deemed necessary by _____ or in the event that he/she is not available, by another licensed physician, and the transfer of my children, named above to _____ hospital/clinic or the closest medical facility.

This authorization does not cover major surgery unless the medical opinion of the two other licensed physicians concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Parent's Signaure: _____ Date: _____