MEDICAL RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above-named rider be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named rider.

Rider's Birth Date: _____

Known allergies of this rider, including any allergies to medicine

_____

_____

_____

Family Physician: _____ Phone: _____

Name of Parent/Guardian _____

Address: _____

City/State/Zip Code: _____

Phone: (H) _____ (Cell Phone) _____

Person responsible for charges (if different from above): _____

Address: _____

City/State/Zip Code: _____

Phone: _____

Person to notify if parent/guardian is unavailable: _____

Phone: _____

Insurance Carrier: _____ Group Number: _____

Signature of Parent/Guardian _____