

# MEDICAL RELEASE FORM

Student's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Parent's Name: \_\_\_\_\_  
Child's SSN \_\_\_\_\_  
Birthdate \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Primary Care Physician Name & Number \_\_\_\_\_  
\_\_\_\_\_  
Allergies \_\_\_\_\_  
Medications \_\_\_\_\_  
Date of last tetanus shot \_\_\_\_\_  
Emergency Contact & Phone Number \_\_\_\_\_  
Alternate Emergency Name & # \_\_\_\_\_

I/We, the undersigned, are the parents having legal custody, or are the legal guardians of

(STUDENT'S NAME)

\_\_\_\_\_, a minor, and have given our consent for him  
to be administered proper medical treatment, as deemed necessary by a licensed physician/doctor. I/We

(ADULT LEADER'S NAME)

authorize \_\_\_\_\_ to give consent in case we cannot be reached or  
because of emergency.

Student's Name: \_\_\_\_\_

Student's Signature: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Phone #: \_\_\_\_\_

Date: \_\_\_\_\_