MEDICAL RELEASE FORM

Child's Name____________________________________ Age____________ Gender________________

Parent or Guardian's Name______________________________ Phone #__________________________

Person to Contact in Case of Emergency Relationship Phone Number

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Insurance Company_____________________________ Phone Number___________________________

Policy____

Family Doctor __________________________________ Phone Number___________________________

Please list any medical conditions and medications on the lines below.

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I hereby give permission for my child to be administered medical treatment by a licensed physician in case of an emergency.

Parent or Guardian's Signature____