

MEDICAL RELEASE FORM (MINORS)

Name _____ Date of Birth _____

Parent/Guardian Name (If applicable) _____

Address _____

Telephone Numbers: Home: _____ Work: _____

Please indicate another person to contact in the event of an accident

Name _____ Phone _____

Insurance Company _____ Policy Number _____

Are you presently on any medication? _____
(If yes, please list medication)

Drug Sensitivities _____

Other Allergies _____

Please read the alternative statements below and sign under the one that you choose.
Do Not sign more than one!

1. If my child needs medical attention, it is my wish that I am contacted before any medical procedures are done on my child, unless immediate treatment is necessary to save my child's life or to prevent permanent injury.

Signature of Parent/Guardian _____
Date

2. If my child needs medical treatment while participating, it is my wish that the treatment be begun while efforts are being made to contact me. So that treatment is not delayed, I consent to any medical procedures that the physician believes needed, on the understanding that efforts will continue to be made to contact me. I accept responsibility for all cost related to such treatment.

Signature of Parent/Guardian _____
Date