

# **MEDICAL RELEASE FORM**

## Parental Consent for Medical Treatment

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  
Last First M.I.

ADDRESS: \_\_\_\_\_ MN \_\_\_\_\_  
Street & Number City Zip

PARENT/GUARDIAN \_\_\_\_\_

PHONE HOME: \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_

PHONE HOME: \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

1. ALLERGIES to food, medications, etc. (If none, state it so):  
\_\_\_\_\_

2. SPECIAL MEDICAL PROBLEMS: (If none, state it so):  
\_\_\_\_\_

3. Does participant carry or require MEDICATION? (If none, state it so):

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Purpose \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Purpose \_\_\_\_\_

4. Does participant have permission to take any of the following if needed (please circle if so):

TYLENOL

IBUPROFEN

BENADRYL

5. Any specific ACTIVITIES to be ENCOURAGED: \_\_\_\_\_

RESTRICTED: \_\_\_\_\_

6. SPECIAL DIET? \_\_\_\_\_

7. Date of last TETANUS SHOT: \_\_\_\_\_

8. Family PHYSICIAN: \_\_\_\_\_ CLINIC \_\_\_\_\_

ADDRESS \_\_\_\_\_ MN \_\_\_\_\_

Street & Number

City

Zip

Phone Number: \_\_\_\_\_

9. INSURANCE: Company \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_ Dep# \_\_\_\_\_

I, the undersigned, being the parent, legal next-of-kin, or legal guardian of \_\_\_\_\_ hereby authorize any necessary medical treatment for this person for 18 months from the date signed. I also guarantee payment of all charges incurred during the course of said medical treatment (physician, hospital, X-ray, lab, medication, ambulance, etc.)

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_