# MINOR MEDICAL RELEASE FORM

In case of emergency, I grant consent to:

_____

to authorize madical care for my minor child/children named below:

_____

Our family doctor is: _____ Phone: _____

The hospital we use is: _____

Allergies: _____

Contact me immediately at: _____

Alternative contact person name and number: _____

_____

Parent/guardian signature:

_____

Name: _____

Address:_____

_____

Phone:_____ Date:_____

**THIS FORM HAS NO EXPIRATION DATE BUT MAY BE REVOKED BY THE PARENT OR GUARDIAN AT ANY TIME.**