Medical Release Form
Treatment of Minor Child

In case of emergency, I grant consent to: ______________________________

to authorize medical care for my minor child/children:

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Our family doctor is: ______________________________

The hospital we use is: ______________________________

Allergies: ______________________________

Contact me immediately at: ______________________________

Alternative contact name and number: ______________________________

Signature ______________________________

Name ______________________________

Address ______________________________

Phone ______________________________

Date ______________________________