MEDICAL RELEASE FORM

Authorization
For Medical Treatment of Minors

Names of Minors	Birthdates	Special Conditions

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

Name	Address	Phone

To act in my behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence, from:

_____ _____ _____ Through _____ _____ _____

Month Day Year Month Day Year

This Document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required

Parent/ Guardian		Parent/ Guardian	
Signature	Date	Signature	Date
Address		Address	
Witness		Witness	
Signature	Date	Signature	Date
Address		Address	

Hospitalization coverage for above named minor(s):

Insurance company or Gov. Plan	I.D. or Contract Number

Family Physicians:

Name and Phone Number	Name and Phone Number