HOSPITAL RELEASE

2018-2019

Both parents MUST sign this document. All fields MUST be completed. Thank you.

I, ___________________________, give permission for my child, ___________________________,

to be treated by Dr. _________________________, at ____________________________________.

If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility for payment of any transportation or emergency medical services rendered.

Child's Full Name:____ ☐ Male ☐ Female

Date of Birth:____

Allergies:____

Date of last Tetanus Shot: ____

Insurance Plan Name:____

Mother's name:____Phone:__________________

Cell Phone:__________________

Father's name:____Phone__________________

Cell Phone:__________________

Emergency Contact Person Name:____

Cell Phone:_________________________

____ ______________________

Parent signature Date

____ ______________________

Parent signature Date

Revised 4/26/2018