



HOSPITAL RELEASE

2019-2020

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