

**TO WHOM IT MAY CONCERN:**

As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor/minors in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor \_\_\_\_\_  
Relationship \_\_\_\_\_

Name of Minor \_\_\_\_\_  
Relationship \_\_\_\_\_

Name of Minor \_\_\_\_\_  
Relationship \_\_\_\_\_

Date or dates when release is intended

\_\_\_\_\_  
Address (home) \_\_\_\_\_ City

\_\_\_\_\_  
Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_  
(cell) \_\_\_\_\_

Family Physician \_\_\_\_\_ Physician Ph.

\_\_\_\_\_  
Specific medical allergies, chronic illnesses or other conditions

\_\_\_\_\_  
Other contact in case of emergency: Name

\_\_\_\_\_  
Phone \_\_\_\_\_

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed \_\_\_\_\_ Date