

EMERGENCY RELEASE FORM

This form must be notarized

I hereby give my consent to _____ to authorize medical treatment
Provider's Name(s)

for my child(ren), _____,
(Name(s) of Child(ren))

should it be necessary while my child(ren) is/are in her/his care.

Parent Signature _____ Date _____

Notary _____ Date _____

PHYSICIAN AND INSURANCE INFORMATION

Child's Name _____

Child's Physician _____

Physician=s Address _____

Physician=s Phone # _____

Health Insurance Carrier _____

Insured's Name _____

Policy, group, etc. # _____
