

## **Medical Release Form**

## Except for signature, please print. Thank you!

As the parent or legal guardian of	ay be admitted to any hospital or medic and staff, duly licensed as Doctors of Me any diagnostic procedures, treatment pr or. I have not been given a guarantee a	edicine or Doctors of Dentistr cocedures, operative s to the results of examination
Date of Birth: / / year	Date of last Tetanus Booster:	month day year
Known allergies of this minor, including any allergies to		month day year
Any other medical problems which should be noted:		
Family Physician:	Phone: ( )	
Name of Parent / Guardian:		
Address:		
City, State, Zip:  Phone: Work:		
Person responsible for charges (if different from above) Address:  City, State, Zip: Phone: Work:		
Person to notify if Parent / Guardian is unavailable: Phone: Work:		
Insurance Carrier:	Policy Numb	er:
Signature	of Parent or Guardian	
State of Indiana ) ) SS: County of )		
Before me, a Notary Public in and for said County and S execution of the foregoing, and who, having been duly s		
Subscribed and sworn before me this	day of	,
		Notary Public
Commission Expires:		
County of Recidence		