

**Medical Release Form**

Parent/Legal Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #s: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Other (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Children's Names	List all known Medical Conditions, including Food Allergies and/or Drug Allergies. In Addition, Include Any and All Over-the-Counter and/or Prescription Drugs Taken Regularly.

In an emergency, please contact: \_\_\_\_\_

Relationship to child/children: \_\_\_\_\_

Phone #s: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Or contact: \_\_\_\_\_

Relationship to child/children: \_\_\_\_\_

Phone #s: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #s: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #s: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_