# MEDICAL & DENTAL RELEASE FORM

# FOR MINOR

I, Ms. , certify that I am the parent or legal guardian of the minor child listed below, and as such, I hereby convey temporary authority to the below designated adults for the sole purpose of obtaining or arranging any emergency medical or dental care for the minor child as may be deemed necessary for the well-being of my child when not accompanied by a parent/legal guardian or should either parent/legal guardian be unreachable by telephone.

***THEREFORE***, I hereby approve and empower the below listed individuals with the authority to arrange and/or consent for any and all emergency medical/dental care and treatment of my child in my absence.

| | |
|---|---|
| (Signature of Parent/Legal Guardian) | (Date) |
| (Name of Parent/Legal Guardian) | (Relationship to Child ) |
| (Home/Work Number) | (Cell Number) |

***MINOR CHILD***

**Child's Name**:
**Address**: , ,
**Telephone Number**:
**Date of Birth**:
**Parent/Legal Guardian**:
**Address**: , ,
**Home/Work Telephone**:
**Cell Telephone**:
**Allergies**:
**Medical Conditions**:
**Current Medications**:

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## ***PRIMARY AND ALTERNATE CHILD CARE PROVIDER***

(Primary Child Care Provider Name) (Relationship to Minor Child)

(Home/Work Telephone Number) (Cell Phone Number)

(Alternate Child Care Provider Name) (Relationship to Minor Child)

(Home/Work Telephone Number) (Cell Phone Number)

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## ***AUTHORIZED EMERGENCY CONTACTS***

(Emergency Contact Name) (Relationship to Minor Child)

(Home/Work Telephone Number) (Cell Phone Number)

(Emergency Contact Name) (Relationship to Minor Child)

(Home/Work Telephone Number) (Cell Phone Number)

## ***HEALTH INSURANCE & DOCTOR INFORMATION***

**Insurance Company**:

**Policy Number**:

**Group Number**:

**Physician's Name**:

**Address**: , ,

**Telephone Number**: