EMERGENCY MEDICAL RELEASE

Please Print Information

Child's Full Name:_____ Birthdate:_____

Allergies:_____

Medicines Routinely Taken:_____

Name of Custodial Parent(s)/Legal Guardian(s):_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Home Telephone _____ Cell Telephone_____ Work Telephone _____

Family Physician's Name/Health Care Resource:_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone (___) _____

Hospital Preference:_____
Name *City*

Medical Insurance Company:_____

Policy #:_____ Expiration Date:_____

Emergency Contact (if custodial parent/guardian cannot be reached**):**_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City,* *State,* *Zip Code*

Home Telephone _____ Cell Telephone _____ Work Telephone _____

Sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child _____, in the event of an emergency at which time
(Child's Full Name)
I cannot be reached. I give consent to transport by ambulance if situation warrants it.

_____
Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me on _____ _____ 20_____
(Month) *(Day)* *(Year)*

by _____, who is personally known to me or who has
(Name of Affiant)

produced _____ as identification. SEAL OF NOTARY
(Type of Identification)

Signed:_____
(Signature of Notary)

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