MEDICAL RELEASE

(I)(We), the undersigned, parent(s) of _____, a minor,

do hereby authorize _____

as agent (s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable.

These authorizations shall remain effective until _____, 20_____, unless sooner revoked in writing delivered to said agent(s).

Father _____ Date _____

Mother _____ Date _____

Legal Guardian_____ Date _____

**Copies of legal guardianship must accompany this form.*

Child's Date of Birth_____ Date of Last Tetanus Shot _____

Medical Allergies_____

Current Medications _____

INSURANCE INFORMATION

Name of Insured_____ Social Security Number _____

Insurance Company_____ Policy/Group Number _____

Insurance Company Address _____

Employer's Name_____ Telephone _____

Family Physician (Pediatrician)_____ Telephone _____

Authorized Agent (Must be over 18 years of age) Name _____

Address_____ Telephone _____

Signature

_____