



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 ()

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 (Child's Full Name), in the event of an emergency at which time 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 (Month) (Day) 20 (Year)

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

produced (Type of Identification) as identification.

SEAL OF NOTARY

Signed: (Signature of Notary)