# 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 _____

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**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)*

SEAL OF NOTARY

produced _____ as identification.
*(Type of Identification)*

Signed:_____
*(Signature of Notary)*