Medical Release

Name of Child: _____ Age: _____ Date of Birth: _____

I/We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I/We may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give *(SITE NAME)* staff and faculty the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization relieve the physician, dentist, person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that *(SITE NAME)* shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by Villa Lyan. I understand that this form is in effect from the date signed and that it is my responsibility to inform *(SITE NAME)* of any changes to this form.

Signature of Mother/Legal Guardian:_____ Date: _____

Mother's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____ Work Phone: _____

Signature of Father/Legal Guardian:_____ Date: _____

Father's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State/Zip: _____ Work Phone: _____

Pediatrician's Name: _____ Telephone Number: _____

Hospital Preference: _____ Telephone Number: _____

Address: _____ City/State/Zip: _____

Insurance Company: _____ Policy/Group #_____

Date of Minor's Last Tetanus Shot: _____ List Current Medications: _____

Allergies: _____ _____

_____ _____

Medical history or other important fact that should be known: _____

_____

_____