



# 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 \_\_\_\_\_, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if situation warrants it.

(Child's Full Name)

## 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.  
(Type of Identification)

SEAL OF NOTARY

Signed: \_\_\_\_\_  
(Signature of Notary)