

Medical Release

CHILD'S FULL NAME _____

In the event that my child becomes ill or sustains an injury while in the care of the Children's Center, I give my permission to those in charge to take whatever steps are necessary to give urgent first aid care.

If it is not possible to reach me or the physician named below consent is given to any licensed physician and/or surgeon to treat, administer drugs or medicines and to perform such surgical procedures as the physician shall think the existing emergency requires for the relief of pain and to preserve my child's life and health.

I give my permission for my child to be transported by ambulance or in a staff member's private car if necessary.

I have listed below all known allergies or reactions my child has to any drugs or medication.

EMERGENCY MEDICAL RELEASE FORM

Child's full name _____

Home address _____ Telephone _____

Telephone where authorizing parent can be reached _____

Child's Physician _____ Telephone _____

Office address _____

Hospital preferred _____

Known allergies _____

Parent or Guardian Signature

Date