



EMERGENCY MEDICAL RELEASE

This form must contain only one child's name, be the original notarized form, and is valid for one year from the date of notarization.

Please Print Information

Child's Full Name: _____ **Birthdate:** _____

Allergies: _____

Medicines Routinely Taken: _____

Name of Custodial Parent(s)/Legal Guardians: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physician's Name/Health Care Resource

Address: _____

Work Phone: _____

Hospital Preference: _____
Name

Medical Insurance Company: _____

Policy Number: _____ Expiration Date: _____

Emergency Contact (if custodial parent/guardian cannot be reached): _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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.

Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me on _____ (Month) _____ (Day) _____ (Year)

by _____, who is personally known to me or who has produced _____ as identification.

Signed: _____

SEAL OF NOTARY