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Medical Release Form

www.allergyfreetable.com

Child's Information					
Child's Name					
Parent or Guardian's Name					
Age		Blood Type		Weight	
Medication Allergies					
Food Allergies					
My child carries an ☐ EpiPen, ☐Twinject for treatment of allergic reactions due to food allergies					
Other Allergies					
Medical Conditions / History					
Current Medications					
Date of last Tetanus Shot					

Parent's or Guardian's Contact Information		
Home Phone #		Parent's Address
Father's Mobile #		
Mother's Mobile #		
Alternative Phone #		
Alternative Contact Name:		Alternative Contact Phone#
Alternative Contact Name:		Alternative Contact Phone#

Family's Doctor Information	
Name	
Phone #	
Address:	

Insurance Information	
Provider	
Insured Name	
Group ID#	
Policy ID#	

I, _______________________________ give permission for the child listed above to receive medical treatment in the event of an emergency, accident, injury or sickness. I give authorization for treatment to all medical personnel, including licensed physicians, nurses, technicians, emergency responders, and other medical personnel. I also assume responsibility for the cost of treatment.

Parent's or Guardian's Name	Parent's or Guardian's Signature	Date