Medical Treatment Authorization and Release

Please fill out this form completely. This document authorizes emergency medical treatment and releases liability for the named patient. Print this form after completion for physical signatures.

1. Patient Information

Full Name of Patient:

Date of Birth: MM/DD/YYYY

Home Address:

City, State, Zip:

2. Parent / Guardian Information (If Patient is a Minor)

Parent/Guardian Full Name:

Relationship to Patient:

Primary Phone Number:

Alternative Phone Number:

3. Emergency Contact (Alternative)

Emergency Contact Name:

Relationship:

Phone Number:

4. Medical History & Insurance

Known Allergies (including medications):

Current Medications:

Chronic Conditions / Physical Limitations:

Health Insurance Provider:

Policy / Group Number:

5. Authorization and Release

I, the undersigned parent, guardian, or legal representative, hereby authorize any licensed physician, hospital, clinic, or other healthcare provider to provide medical, surgical, or dental treatment, including administering anesthesia, to the patient named above in the event of an emergency. I accept full financial responsibility for all medical treatment administered.

I hereby release, waive, and covenant not to sue the organization, its directors, officers, employees, and agents from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by the patient while participating in activities or receiving medical care under this authorization.

6. Signatures (Sign after printing)

Authorized Person Print Name:

Relationship to Patient:

Date: MM/DD/YYYY

Physical Signature: ____