

MEDICAL CONSENT / RELEASE FORM

As the parent/legal guardian of _____, I request that in my absence the above named child be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, nurses, dentists and staff, to perform any diagnostic procedures, treatment procedures, and operative procedures to the above named individual. I have not been given any guarantee as to the results of any treatment if performed on the above name individual.

I hereby accept any financial responsibility for any and all medical treatment necessary to be administered to the above named child in the event of an accident, injury, sickness, etc.

Any representative of Panther Creek is designated to act in my behalf until I have been contacted.

Date of birth ___/___/___ for the above named individual.

Date of last Tetanus Booster ___/___/___ for the above named individual.

Known allergies and reactions of the above named individual, including any allergies to medicine:

Any other special medical problems that should be noted about the above named individual.

Any medications that the above named individual will be bringing with them.

Family Physician _____ Phone Number _____

Names of Parents/Guardians: _____

Address: _____

City/State/Zip _____

Phone: H _____ W _____ Other _____

Person Responsible for charges (if different than above) _____

Address: _____

City/State/Zip _____

Phone: H _____ W _____ Other _____

Other Person to notify if parent/guardian is unavailable _____

Phone: H _____ W _____ Other _____

Insurance Company _____ Policy or Group Number _____

Signature of Parent/Guardian _____

Date _____

