



**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:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

Allergies: \_\_\_\_\_

Medicines Routinely Taken: \_\_\_\_\_

**Name of Custodial Parent(s)/Legal Guardian(s):** \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address (number, apartment #, street) City State Zip Code*

Home Telephone \_\_\_\_\_ Cell Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Home Telephone \_\_\_\_\_ Cell Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

**Physician's Name/Health Care Resource:** \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address (number, apartment #, street) City State Zip Code*

Telephone \_\_\_\_\_

**Hospital Preference:** \_\_\_\_\_  
*Name City*

**Medical Insurance Company:** \_\_\_\_\_

Policy #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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

Address: \_\_\_\_\_  
*Street Address (number, apartment #, street) City, State, Zip Code*

Home Telephone \_\_\_\_\_ Cell Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

**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  
*(Child's Full Name)*

I cannot be reached. I give consent to transport by ambulance if situation warrants it.

**Signature of Custodial Parent/Legal Guardian (Affiant):** \_\_\_\_\_  
*Signature of Custodial Parent/Legal Guardian*

**STATE OF FLORIDA COUNTY OF** \_\_\_\_\_

The foregoing instrument was acknowledged before me on \_\_\_\_\_ 20\_\_\_\_\_  
*(Month) (Day) (Year)*

by \_\_\_\_\_, who is personally known to me or who has  
*(Name of Affiant)*

produced \_\_\_\_\_ as identification.  
*(Type of Identification)*

Signed: \_\_\_\_\_  
*(Signature of Notary)*

SEAL OF NOTARY