

# Emergency Contact Information & Medical Release Form

**Mother's First & Last Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Father's First & Last Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Additional Emergency Contacts:** (home/cell numbers)

Name: \_\_\_\_\_ relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Is your child covered by Medical Insurance? \_\_\_yes\_\_\_no

**IF YES-**Insurance carrier \_\_\_\_\_ policy # \_\_\_\_\_

---

I hereby give permission for certified and licensed medical personnel to use appropriate procedures to aid my daughter/son, \_\_\_\_\_ and prevent further injury and/or death. If possible, I wish to be contacted before any procedures are initiated, however, if the injuries are catastrophic and life threatening, I give permission to the emergency care physicians and support personnel to do what they deem necessary in the best interests of my child.

\_\_\_\_\_  
Parent or legal guardian signature

\_\_\_\_\_  
Date