FLORIDA DEPARTMENT OF HEALTH

Emergency Medical Release

Child's Full Name: _____ DOB: _____

Allergies: _____ Medicines Routinely Taken: _____

Surgeries:_____ Seizures: _____YES_____No

Name of Custodial Parent(s) or Legal Guardian(s): _____

Address: _____ City: _____ State: ___ Zip: _____

Home Telephone: _____ Cell Telephone: _____ Work Telephone: _____

Home Telephone: _____ Cell Telephone: _____ Work Telephone: _____

Family Physician's Name/Health Care Resource: _____

Address: _____ City: _____ State: ___ Zip: _____

Telephone #: _____

Hospital Preference: _____, City:_____

Medical Insurance Company: _____

Policy #: _____ Expiration Date: _____

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

Address: _____ City: _____ State: ___ Zip: _____

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 I cannot
(child's full name)
be reached. I give consent to transport by ambulance if situation warrants it.

_____
Signature of Custodial Parent/Legal Guardian (Affiant)

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 produced
(Name of Affiant

_____ as identification. SEAL OF NOTARY
(Type of Identification)

Signed: _____
(Signature of Notary)