Medical Release Form

www.allergyfreetable.com

Child's Information									
Child's Information Child's Name									
		Nama							
Parent or Guardian's Name				Dlood Type	1			Maight	
Age				Blood Type				Weight	
Medication A	liergies								
Food Allorgia									
Food Allergie	3								
My child carries an □ EpiPen, □Twinject for treatment of allergic reactions due to food allergies									
Other Allergies									
Medical Conditions / History									
	•	•							
Current Medications									
Date of last Tetanus Shot									
•									
Parent's or Guardian's Contact Information									
Home Phone #					Parent's Address				
Father's Mobile #									
Mother's Mobile #									
Alternative Phone #									
Alternative Contact Name:					Alternative Contact Phone#				
Alternative Contact Name:					Alternative Contact Phone#				
Family's Doctor Information					Insu	ranc	e Information		
Name	,			-		Provider			
Phone #						Insured Name			
Address:						Group ID#			
1					Policy ID#				
I, give permission for the child listed above to receive medical									
treatment in the event of an emergency, accident, injury or sickness. I give authorization for treatment									
to all medical personnel, including licensed physicians, nurses, technicians, emergency responders, and									
other medical personnel. I also assume responsibility for the cost of treatment.									
Describe on Consultanta Name									

Parent's or Guardian's Name	Parent's or Guardian's Signature	Date