

MEDICAL RELEASE FORM

I, _____(Parent/Guardian’s Name) hereby give permission for any and all dental attention to be administer to my child _____(child’s name).

In the event of accident, injury routine dental care etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment.

Name:_____

Address:_____

Phone Number:_____

Insurance Co._____

Policy Number & Phone Number:_____

In case I cannot be reached, any of the following persons are designated to act on my behalf.

* *Relatives: Name and Relation:*_____

* *Friends:*_____

* *Baby Sitter/Child Care:*_____

* *Church Member or any Sports Representative* where my child is attending or playing:_____

PHYSICIAN:

Name:_____

Phone Number:_____

KNOWN ALLERGIES/ILLNESS:_____

SIGNATURE (Parent/Guardian)_____Date_____

This _____day of _____,200_____

Notary Public_____