CITY OF TREASURE ISLAND
MEDICAL EMERGENCY RELEASE FORM

I hereby give my consent to any EMERGENCY MEDICAL SERVICE/HOSPITAL FACILITY AND/OR PHYSICIAN to administer necessary treatment to my child _____ (Child's Full Name) in the event of an emergency at which time I cannot be reached. I give consent to transport by AMBULANCE/MEDICAL SERVICE to such hospital facility EMERGENCY MEDICAL SERVICE deems appropriate.

Hospital Preference (if applicable):_____

Child's Full Name_____Birthdate:_____

Physician_____Address_____Phone#_____

Allergies_____ Medication Routinely Taken_____

Date of last DPT or Tetanus_____ Medical_____

Child's Insurance Company_____ Policy #_____Date of Issue_____

Emergency Contact_____ Cell #_____ Work #_____

Address: _____ City_____ State_____ Zip_____

_____ _____ Date_____
Signature of parent or legal guardian Print Name

State of _____

County of _____

On the ___ day of _____, 20__, before me came_____, who is personally known to me or has produced _____ (Type of Identification) as identification, who executed the foregoing instrument and acknowledge that he/she executed the same.

NOTARY PUBLIC:_____