

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 _____ in
(Child's Full Name)
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 _____

Signature of parent or legal guardian _____ Print Name _____ Date _____

State of _____

County of _____

On the ___ day of _____, 20___, before me came _____, who is personally known to
me or has produced _____ as identification, who executed the foregoing
(Type of Identification)

instrument and acknowledge that he/she executed the same.

NOTARY PUBLIC: _____

