SCSA Medical Release Form

As the parent or legal guardian of _____,
I request that in my absence, the above-named minor may be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctor of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above-named minor. I have not been given a guarantee as to the results of examination or treatment. I authorized the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

Date of Birth:	|___/ ___/ _____|
Date of last Tetanus Booster:	|___/ ___/ _____|

Medical Awareness	
Known Allergies	
Other Medical Requirements	

Physician Information	
Family Physician Name	
Phone Number	

Emergency Contact Information		
Contact #1	Name	
	Relationship	
	Phone Number	
Contact #2	Name	
	Relationship	
	Phone Number	

Who To Contact For Medical Expenses			
Name		Phone	
Address		City	
State		ZIP	