Print

MEDICAL RELEASE
Kinship of the Park Rapids Area

I hearby authorize my child's mentor _____,
Kinship staff or any other volunteer with Kinship of the Park Rapids Area to

secure emergency medical attention for my child, _____,
in the event that I cannot be contacted.

Our local doctor_____

phone_____ has my permission to release any records that may be
needed to treat my child in an emergency.

For emergency purposes, I can be reached at: 1) Home_____

2) Work_____ 3) Other_____

My closest friend/relative is_____ phone_____

Relationship:_____

Allergies my child has:_____

Regular medication my child receives:_____

Phobias or fears my child has:_____

Any other important medical information:_____

_____

_____

If you are on Medical Assistance or have insurance or an HMO, please give number to be used:

_____

_____ _____
Date Signature