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MEDICAL CONSENT FORM

I, _____ of _____ confirm that I am the legal guardian of the child listed below.

SECTION 1: INFORMATION OF CHILD/MINOR

_____, born _____ at _____ and residing at

_____

Health insurance information:

_____

Medications currently used:

_____

Illnesses, medical conditions, and/ or allergies:

_____

SECTION 2: MEDICAL AUTHORIZATION DETAILS

I hereby authorize and appoint _____ of _____ as my Agent. My Agent may consent to emergency and routine medical treatment for my child when required.

My Agent may have access to any and all records, including, but not limited to, insurance records regarding any medical services or treatment provided.

Our family doctor may be contacted at:

Name: _____

Address: _____

Phone Number: _____

Email: _____

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This authority will be effective throughout the [event] as of the # day of [month], 2026 and will remain in effect until the # day of [month/year]. In case this time period has to get extended due to unforeseen trip delays, the legal guardian will be contacted.

SECTION 3: PARENT / GUARDIAN CONTACT DETAILS

Any questions or concerns regarding this authorization may be directed to the child's legal guardian at:

Name: _____

Address: _____

Phone Number: _____

Secondary Phone: _____

Email: _____

If the child becomes ill or injured, the Agent will first try to contact the parent/ guardian. If the parent/ guardian cannot be reached, the Agent will contact the following emergency contact:

Name: _____

Phone Number: _____

Secondary Phone: _____

SECTION 4: ACKNOWLEDGEMENT & SIGNATURES

I understand why I have been asked to provide consent to Medical Release for the above-mentioned child and am aware of the risks and benefits of consenting.

_____
Signature of parent/ legal guardian

_____
Name of parent/ legal guardian