



Medical Consent and Release

We, the undersigned parents or legal guardians of the minor child or children listed below:

Name (Please print) _____

Date of Birth: _____

do hereby authorize any hospital service, x-ray, examination, anesthetic, dental, medical or surgical diagnosis or treatment by any licensed physician or dentist, and hospital service that may be rendered to said minor or minors under the general, specific or special consent of Long Walk, the temporary custodians of the minor child.

I/We authorize the physician or dentist to call in any necessary consultants in his/their discretion.

It is understood that the consent is given in advance of any specific diagnosis or treatment being required but is given to encourage those persons who have temporary custody of the minor or minors and said physician or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

This consent shall remain effective until _____ pm on the _____ day of _____, 2009, unless sooner revoked in writing and delivered to said physician or dentist or said persons entrusted with the custody, care and control of said minor child or children.

Known Medical Conditions/Allergies to Medications or Foods: _____

Current Medications: _____

Health Insurance:

Company Name: _____

Insured's Name: _____

Telephone Authorization # _____

Policy # _____

Group # _____

Health Insurance:

Company Name: _____

Insured's Name: _____

Telephone Authorization # _____

Policy # _____

Group # _____

Signed this _____ day of _____, 2009.

Father's Signature

Home Phone

Work Phone

Cell Phone

Mother Signature

Home Phone

Work Phone

Cell Phone