URBAN TRIAGE

RETURNING TO OUR PAST TO HEAL FOR OUR FUTURE

Release Form

Name of Minor Child: _____

Age: _____ Date of Birth: _____/_____/_____

We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such times as the medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give _____ (name of guardian over 18) the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that this authorization relieves the physician, dentist, or other person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that the above-named guardian shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given but are in no way intended to restrict the giving of authorization or consent by the above-named guardian. I understand that this form is in effect from the date signed and that it is my responsibility to inform Urban Triage, Inc of any changes to this form.

_____ _____

(Signature of Parent) (Date)

_____ _____

(Signature of Guardian over 18) (Date)

Emergency Contact Information:

Parent/Guardian Name:

_____

Address:

_____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Health Insurance Information:

Company or Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Policy Holder: _____

Policy/Contract #: _____ Expiration Date: _____

Physician Information:

Physician Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Minor Child: _____

Age: _____ Date of Birth: _____/_____/_____

Do you have a medic alert tag? If so, for what condition?

_____

Known Allergies (food, insects, medication, others):

_____

_____

_____

Do you carry medication for your allergies? (If yes, list the medications and dosages):

Current medications (include herbal, and over the counter, as well as prescription medications):

Medical history (including medical conditions or other important facts that should be known):

Special beliefs (any religious or other beliefs that might have an effect on medical care such as blood transfusions, etc.):