MEDICAL RELEASE

I, _____, am the parent or legal guardian of _____ (hereinafter "my child"), who was born on _____.

I hereby authorize **Kim Mitchell**, into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a licensed dentist for my child.

I further authorize **Kim Mitchell** to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to Kim Mitchell.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of **Kim Mitchell** or her authorized designee, in the exercise of his/her best judgment, upon advice of such physician, dentist, and surgeon, may deem advisable.

I agree that I am ultimately responsible for the cost of any medical care not reimbursed by my health insurance provider or if I do not carry any health insurance. I also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary.

Print Name of Parent/Guardian _____.

Dated _____

Signature of parent/guardian _____

Health Information

Medical/Health Insurance Company _____ Insurance Policy # _____

Allergies/Allergic reactions of my child:

Medicine being taken by my child:

Other information regarding my child's health that a doctor should know (write on back)

Please make a copy of your health insurance card and attach to this sheet. Thank you.