

**MQH AFTERCARE PROGRAM
MEDICAL RELEASE FORM
2018-2019**

I, _____, parent or guardian of _____,
hereby authorize transportation and emergency medical treatment
deemed necessary for above-mentioned child in my absence.

The above-mentioned child, _____ has the following
known allergies or medical conditions: _____

Medical Insurance:

Company Name: _____

Policy Number: _____

Group Number: _____

Dated: _____

Signature: _____

Parent or Legal Guardian