



**Children's House of Weld County: Montessori
Treatment Release**

As a parent/guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship: _____

Specific medical allergies, chronic illnesses, or other conditions: _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature of Mother/Guardian: _____ Date: _____

Signature of Father/Guardian: _____ Date: _____

Family's Contact Information

Mother Phone: _____ Work Phone: _____ Cell Phone: _____

Father Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____

Emergency Contact Information when Parent/Guardian is Unavailable

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____

Physician's Contact Information

Child's Physician: _____ Telephone: _____

Address: _____ City: _____ Zip: _____

Dentist's Contact Information

Child's Dentist: _____ Telephone: _____

Address: _____ City: _____ Zip: _____

Hospital Information

Hospital of Preference: _____ Telephone: _____

Address: _____ City: _____ Zip: _____

Insurance Information

Insurance Carrier: _____ Telephone: _____

Policy Number: _____ Group Number, if available: _____