

MEDICAL AUTHORIZATION RELEASE

We/I authorize Carol A. Ryder and her assign substitute or representative permission and authority to obtain and execute the necessary medical treatment in the event my child experiences a life treating or accidental medical emergency.

Parent's name (Print)

Parent's Signature

Date

Medical Information:

Physician's _____
Name address phone

Dentist's: _____
Name address phone

Name of medicine	reason for use	Can your child be given fever reducers?
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Medication: _____

Medical instructions
Or comments: _____

Does your child have any special needs? Yes____ No____

If yes, please explain:

