



**Foster City Parks and Recreation Department
Youth and Teen Programs**

MINOR MEDICAL RELEASE FORM

Dear Parent/Guardian:

In the event of any type of injury or illness, whether life threatening or not, your signature on this form will authorize, in your absence, medical treatment as deemed necessary by a licensed physician/surgeon/dentist. Without your signature, your child will not be allowed to participate in any Youth or Teen Program function with the City of Foster City. Please submit ONE FORM PER CHILD.

<hr/> Child's Name	<hr/> Child's DOB	<hr/> Parent Contact/Cell Number	
<hr/> Address		<hr/> City	<hr/> State
			<hr/> Zip

The undersigned hereby authorizes the City of Foster City Recreation Staff to inform any licensed physician/surgeon/dentist to proceed with any medical treatment as seen fit or prescribed by a licensed physician/surgeon/dentist, to the minor named above. Any expenses and related costs generated by these steps, treatments, medications, x-rays, anesthetics, or procedures shall be paid by the undersigned.

<hr/> Parent/Guardian Name	<hr/> Signature of Parent/Guardian	<hr/> DATE
<hr/> Employer	<hr/> Work/Day Phone	
<hr/> Evening Phone	<hr/> EMAIL	
<hr/> Medical Insurance Company	<hr/> Policy Number	
<hr/> Name of Physician	<hr/> Phone Number	

In case of emergency in which parent/guardian cannot be reached, the one of the following people should be notified:

<hr/> 1. Contact Name	<hr/> Relation to Minor		
<hr/> Address	<hr/> City	<hr/> State	<hr/> Zip
<hr/> Day Phone	<hr/> Evening Phone		
<hr/> 2. Contact Name	<hr/> Relation to Minor		
<hr/> Address	<hr/> City	<hr/> State	<hr/> Zip
<hr/> Day Phone	<hr/> Evening Phone		

MEDICAL INFORMATION FOR THIS MINOR:

Please list all allergies, including medications: _____

Please list all medication currently being taken: _____

Please list medical history/special needs* that emergency personnel/Staff should be aware of: _____

