

**WICHITA JUNIOR GOLF FOUNDATION  
MEDICAL RELEASE FORM**

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_ do hereby consent to any hospital, medical or surgical care and treatment, and the administration of anesthesia, determined by a qualified physician to be necessary for the welfare of my child while said child is under the care, custody and control of **WICHITA JUNIOR GOLF FOUNDATION** and I am not reasonably available by telephone to give consent.

**Signature of parent or legal guardian** \_\_\_\_\_

**Witness** \_\_\_\_\_

The following information is not required, but could be helpful in any necessary treatment:

\_\_\_\_\_ Family Address

\_\_\_\_\_ Father's Home Phone

\_\_\_\_\_ Father's Work Phone

\_\_\_\_\_ Mother's Home Phone

\_\_\_\_\_ Mother's Work Phone

Child's birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Tetanus \_\_\_\_\_

Allergies to drugs or foods: \_\_\_\_\_

Special medication, blood type or pertinent information: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_

**LIST ADDITIONAL EMERGENCY CONTACT INFORMATION BELOW:**

<u>Name</u>	<u>Relationship to Child</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This Consent to Treatment should be taken with the child to the hospital or physician's office where the child is taken for treatment.