

## MEDICAL RELEASE FOR MINOR CHILD

I, \_\_\_\_\_, Parent or Legal Guardian of  
\_\_\_\_\_, Name of Minor Child,  
hereby authorize Gwinnett Urgent Care to perform any Medical or Surgical treatment  
which may be necessary for the well being of the above mentioned minor. I agree to  
hold the physician and Gwinnett Urgent Care treating the above mentioned minor,  
harmless for rendering such care.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The above mentioned minor has the following Allergies or Medical conditions:

**Medical Condition:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Parent / Guardian Address and Contact Information:**

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Insurance Information (Please Send a Copy of Insurance Card with Minor Child)**

Insurance Company: \_\_\_\_\_

Group Number \_\_\_\_\_

Member ID \_\_\_\_\_

Insurance Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State : \_\_\_\_\_, ZIP: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_