



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: _____