



MEDICAL RELEASE FORM

I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_  
(parent/guardian) (child's name)

born on, \_\_\_\_\_

who attends Prime Time Early Learning Center, 270 Airport Plaza, Farmingdale, NY 11735,  
hereby authorizes \_\_\_\_\_ Hospital, located \_\_\_\_\_  
to provide emergency treatment to child named above in case of injury, accident, and/or  
illness during the school year(s) of

\_\_\_\_\_.

Child's pertinent health information, if any \_\_\_\_\_

\_\_\_\_\_

Child's allergies, if any \_\_\_\_\_

\_\_\_\_\_

Child's doctor's name, address and phone number \_\_\_\_\_

\_\_\_\_\_

Parent's health insurance for child - name and policy number of insurance company

\_\_\_\_\_

\_\_\_\_\_

Medicaid number (if applicable)

\_\_\_\_\_

Emergency person's name, telephone number and relationship to child \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent's signature

\_\_\_\_\_  
Date