



Emergency Release Information

CLIENT INFORMATION

First Name: _____ Last Name: _____ MI: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: (_____) _____

PARENT/GUARDIAN INFORMATION

Father Last Name: _____ First: _____

Phone: (_____) _____

Mother Last Name: _____ First: _____

Phone: (_____) _____

Guardian Last Name: _____ First: _____

Phone: (_____) _____

MEDICAL INFORMATION

Allergic to: _____

Preferred Hospital: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____) _____

Physician Name: _____ Phone: (_____) _____

Dentist Name (optional): _____ Phone: (_____) _____

Please provide three names to call in case of emergency:

1. Name: _____ Phone: (_____) _____

2. Name: _____ Phone: (_____) _____

3. Name: _____ Phone: (_____) _____

I, _____, authorize Millrose Center to release _____ to:

Name: _____ Phone: (_____) _____ DL#: _____

Name: _____ Phone: (_____) _____ DL#: _____

Parent/Guardian Signature

Date