

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: _____