

## MEDICAL RELEASE FORM

I, \_\_\_\_\_ (Parent), hereby give permission for any and all medical and/or dental attention to be administered to my child \_\_\_\_\_ in the event of accident, injury or sickness that may occur while using the facilities owned by Poise Studio, LLC. I assume the responsibility for the payment of any such treatment.

*Please complete as much of the following as possible and applicable:*

PARENT: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDITIONAL CONTACT NUMBERS: \_\_\_\_\_

**CHILD'S NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

KNOWN ALLERGIES: \_\_\_\_\_

MEDICAL/DENTAL CONDITIONS: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

**PRIMARY INSURANCE COMPANY:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ PLAN CODE: \_\_\_\_\_

**SECONDARY INSURANCE CO.:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ PLAN CODE: \_\_\_\_\_

**PRESCRIPTION DRUG CO.:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ PLAN CODE: \_\_\_\_\_

**DENTAL INSURANCE CO.:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ PLAN CODE: \_\_\_\_\_

**PHYSICIAN:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**DENTIST:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

NAME \_\_\_\_\_

WITNESS \_\_\_\_\_