Gwinnett
URGENT CARE

# 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:** |
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| | |

**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: ____________________