GOKIDS BOSTON MEDICAL RELEASE FORM

(Please Print)

Patient's Name:	Phone Number:

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No			Allergies: Allergies to medication(s): Medicine(s) currently being taken:		
Please indicate primary insurance	❑ Blue Cross	❑ Tufts	❑ Harvard Pilgrim	❑ Medicare	❑ Other
Subscriber's name:	S.S. no.	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

IN CASE OF EMERGENCY

First person to contact in the event of an emergency):	Relationship to patient:	Home phone no.: ( )	Alternate phone no.: ( )

I, _____, as parent or legal guardian give my permission and consent
(Parent or Legal Guardian)

for the UMass Boston GoKids Program Director or any appropriately designated staff person, as determined in his/her judgment, to obtain for my child _____, medical or dental emergency treatment or services as appropriate.

(Child)

_____ _____
(Date) (Signature of Parent or Legal Guardian)

_____ _____
Patient/Guardian signature *Date*