**Minor Photo Medical Release Form**

**Parent/Guardian Details
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Alternate Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Minor’s Details
Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_
Known Allergies or Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Primary Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Emergency Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Purpose of Medical Photo Release
I authorize the medical staff at (Healthcare Facility/School/Organization Name) to photograph my child in the event of a medical emergency or for medical documentation purposes. These photographs may be used for:**

**☐ Medical Records Only
☐ Identification in Medical Emergencies
☐ Educational Purposes within the Medical Institution**

**Photographs will be kept confidential and used only as required for medical treatment.**

**Permission to Share with Third Parties
☐ I authorize the release of medical photographs to emergency responders if necessary.
☐ I do NOT authorize any third-party sharing of these images.**

**Revocation and Expiration
This authorization is valid until \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_. Written revocation of this consent is permitted at any time.**

**Parent/Guardian Signature
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_**

**Medical Representative Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_**