**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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_**