

**MEDICAL TREATMENT AUTHORIZATION FORM****To Whom It May Concern:**

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Student's Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Type of activity or school year for which release is intended: \_\_\_\_\_

**PARENTS/LEGAL GUARDIANS**

Father \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Where parents can be reached when not at home:

Father: \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother: \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_ City: \_\_\_\_\_

List allergies, medication, contract, or other pertinent comments:

\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Data:

Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

List a neighbor or close relative who will assume care of your child if you cannot be reached.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Parent or Guardian)