MEDICAL TREATMENT RELEASE FORM

2019-2020

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.

Name of Minor:_____ Relationship to you: _____

Name of Mother: _____ Name of Father: _____

Reason for which release is intended: Family Faith Formation Registration

Address of Minor:_____ City:_____

Emergency Phone Numbers: Mother_____ Father_____

Family Physician _____ Phone # _____

Family Physician Address:_____ City:_____

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

_____

_____

Health Insurance Data:

Company: _____ Policy:_____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgement 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. I acknowledge that it is my responsibility to submit a new form if any of the above information changes.

Date: _____ Signed: _____

(Parent or Guardian)