SACRED HEART CHURCH
MEDICAL TREATMENT AUTHORIZATION FORM

To Whom It May Concern: **Today's Date** _____

As parent/guardian, I do hereby authorize treatment, by 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.

Child Name: _____ **Relationship to you:** _____

Address: _____ **Phone:** _____

Type of activity or school year for which release is intended: Little Flowers Girls' Club/Blue Knights Boys' Club

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, 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 Acknowledgement of Receipt of Notice of 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)