Diocese of Gaylord

4280-School-Form 17

MEDICAL TREATMENT RELEASE FORM

To Whom it May Concern:

As a parent/guardian I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____ Phone: _____

Emergency Phone: _____Cell phone: _____

Family Physician: _____ Phone: _____

Address: _____ City: _____

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

_____

_____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date: _____ Signed: _____
(Parent or Guardian)