MEDICAL TREATMENT RELEASE FORM
St. Patrick Parish, Parnell

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the 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.

1.)_____ 2.)_____ 3.)_____

4.)_____ 5.)_____ 6.)_____

Reason for which release is intended: Faith Formation

Address of Child: _____

Emergency Phone: _____ Name: _____ Relationship to Child: _____
Family Physician: _____ Phone: _____

Physician's Address: _____

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

Child 1_____ Child 2 _____

Child 3 _____ Child 4 _____

Child 5 _____ Child 6_____

Health Insurance Data:

Company: _____ Policy: _____Group: _____

Contract: _____Company Address: _____

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 certify that I am the (check one) ____ custodial parent _____ legal guardian of the minor child(ren) name above.

Date: _____ Signed: _____ Print Name: _____