MEDICAL TREATMENT AUTHORIZATION

(Need one per student)

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.

Name of Minor: _____ Relationship to you: _____

Names of Parents/Guardians: _____

Reason for which release is intended:

This is for classes and events hosted at St. Philip for youth during the 2017-18 religious education school year. Please contact the religious education office if there are any changes during that time.

Address of Minor: _____ City: _____

Emergency Phone(s):_____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medications, contacts, 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.

Date: _____ Signed: _____