

MEDICAL TREATMENT RELEASE FORM

(Each child enrolled in R.E. must have a completed and signed Release Form)

To Whom It May Concern:

As 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: _____

Reason for which release is intended: To attend St. Clare of Montefalco Religious Education Program.

Address of Minor: _____

Telephone # where you can always be reached: _____

Family Physician: _____ Phone: _____

Physician Address: _____

List all allergies, medication, or other pertinent comments:

Health Insurance Information:

Company: _____ Policy: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgment 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: _____