

# 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. The 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: St. Mary Parish, Charlevoix, Michigan, Vacation Bible School June 20-24. 2022

Address of Minor: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Physicians Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Comments/Other: \_\_\_\_\_

Health Insurance Data: \_\_\_\_\_

Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

**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: \_\_\_\_\_

