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: Divine Mercy Parish Faith Formation Programs

Address of Minor:_____

City:_____ **State:**_____ **Zip:**_____ **Phone:**_____

Emergency Phone:_____ **Date of Birth:**_____

Family Physician:_____

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 Acknowledgment 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:**_____