

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of 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 Student: _____ Relationship to you: _____

Reason for which release is intended: **2007-2008 School Year**

Address of Minor: _____ City: _____

Emergency Contact & Phone(s): _____

List a close neighbor/relative who will assume care of your child if you cannot be reached:

Name/Relationship: _____ **Phone:** _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies: _____

List medications taken: _____

Other pertinent comments: _____

Health Insurance Data:

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.

Date: _____

Signed: _____

(Parent or Guardian)