

# **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: **2008-2009 School Year**

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

Emergency Contact & Phone(s): \_\_\_\_\_

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

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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)