

MEDICAL TREATMENT AUTHORIZATION 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.

Student's Name: _____ Relationship to you: _____

Address: _____ Phone: _____

Type of activity or school year for which release is intended: _____

PARENTS/LEGAL GUARDIANS

Father	Address	Phone
Mother	Address	Phone

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Where parents can be reached when not at home:

Father:	Address	Phone

Mother:	Address	Phone

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

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

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

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

Name: _____ Phone: _____

Address: _____ Relationship: _____

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)