

MEDICAL TREATMENT RELEASE FORM
Prince of Peace Catholic Church

ONE PER CHILD

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment by 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 child: _____

Relationship to you: _____

Reason for which release is intended: **Youth Faith Formation, social events, retreats, other events**

Address of Child: _____

Emergency Phone(s): _____

Family Physician: _____

Phone: _____

Physician's Address: _____

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

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

Company Address: _____

I further authorize the person who presents the minor to sign the Acknowledgement 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)

