

## 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: Prince of Peace Faith Formation Classes, Retreats, & 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)

