MEDICAL TREATMENT AUTHORIZATION

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 minor: _____

Relationship to me:_____

Reason for which release is intended: Sophomore Retreat 2022

Address of minor: _____

Emergency phone(s): _____

Family Physician: _____

Phone: _____

Physician's Address: _____

List allergies, medications, contacts or other pertinent comments:

_____

_____

Health insurance data:

Company: _____Policy:_____

Group: _____

Contract: _____

I further authorize the person who presents this minor to sign Acknowledgement of Receipt of Notice Privacy Rights that may 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)