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**

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)