Lakeshore Catholic Communities

Holy Family Church, East Tawas, MI and Sacred Heart Church, Oscoda, MI

MEDICAL TREATMENT RELEASE FORM
2018-19 Faith Formation Year

To Whom It May Concern:

As a parent/guardian, I do herby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Phone: _____ Cell Phone: _____

Family Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

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

Allergies: _____

Medications: _____

Comments/Other: _____

Health Insurance Data: _____

Company: _____ Policy #: _____

Group: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice of 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)