MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern: As a parent/guardian I do hereby 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: _____ DOB:_____Grade:_____

Relationship to you:_____Reason for which release is intended:__**Emergency treatment**_____

Address of Minor: _____

City:_____ State:_____MI_____Zip: _____

Father's Name:_____Address:_____

Father's Cell Phone:_____Father's Work Phone:_____

Mother's Name:_____ Address:_____

Mother's Cell Phone:_____Mother's Work Phone:_____

Emergency Contact (after parents):_____Phone:_____

Family Physician: _____Phone:_____

List allergies, medication, contacts, or other pertinent comments**. Please note all conditions for which the child is currently receiving treatment:**

Allergies: _____

Medications: _____

Comments/Other: _____

Health Insurance Data: Company: _____Policy: _____

Group: _____Contract: _____

Individuals allowed to pick student up: _____

_____

_____

I 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:_____Printed Name:_____

Signature of Parent/Guardian Printed name of Parent/Guardian