All Saints Parish
Medical Treatment Release Form

To whom it may concern:

As a parent/guardian I do hereby authorize the treatment by a qualified and licensed physician in an emergency which, in the opinion of the attending physician, is deemed necessary and appropriate. This authority is granted only after reasonable effort has been made to reach me.

List all students covered by this release:

Name of minor: _____ Relationship to you:_____

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Reason for which intended: Authorizes medical treatment under emergency circumstances in the absence of parent/guardian from **9-1-18 through and including 8-31-19**

Address of minor: _____ Phone: _____
Emergency Phone: _____

Family Physician: _____ Phone: _____
Address: _____ City: _____

List Allergies, medication, contacts, or other pertinent comments: **Include child's name if multiple children are covered by this release.**

Health Insurance Data:
Company: _____ Policy: _____
Group: _____ Contract: _____

Does this policy apply to all children? ____yes _____no (If no, please provide info on reverse side)

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 release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.
DATE: _____ SIGNED: _____
(Parent or Legal Guardian)

MCC:MEDAUTH 2/04

Over