

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:

Student Name: _____ Relationship to you: _____ Grade: _____

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Reason for which intended: Authorizes medical treatment under emergency circumstances in the absence of parent/guardian from 8-1-23 through and including 8-1-24

Address of student: _____ Phone: _____

Emergency Phone: _____

Family Physician: _____ Phone: _____

Address: _____ City: _____

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

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

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

I further authorize the person who presents the student 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)