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:______________________________________Relationship to you:_________________________

Use back of sheet for more than one.

Reason for which release is intended: **Catholic Communities of L'Arbre Croche Youth Ministry Activities, July 1, 2016-June 30, 2017**

Address of Minor:_______________________________________Phone:_______________________________

Emergency Phone:_______________________________________Date of Birth:___________________________

Family Physician:_______________________________________Phone:_______________________________

Address:____City:_____________________________________

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.

PUBLICITY CONSENT: As parent/guardian of the student (s) named above, I understand that promotional pictures & videos (individual & group) may be taken. I give permission for my child's picture, name, age, comments, parish and city to be used for news and promotional materials (including, but not limited to, print, web pages, facebook, calendars, power point, audio, video, broadcast, etc.) for the Diocese of Gaylord and the Catholic Communities of L'Arbre Croche.

Date:_________________________________Signed:____

(Parent or Guardian)

Name of Minor:____Relationship to you:__________________________

Family Physician:____Phone:________________________________

Address:____City:_______________________________________

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

Allergies:____

Medications:____

Comments/Other:____

Health Insurance Data:

Company:____Policy:_________________________________

Group:_______________________________Contract:____

Name of Minor:____Relationship to you:__________________________

Family Physician:____Phone:________________________________

Address:____City:_______________________________________

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

Allergies:____

Medications:____

Comments/Other:____

Health Insurance Data:

Company:____Policy:_________________________________

Group:_______________________________Contract:____

Name of Minor:____Relationship to you:__________________________

Family Physician:____Phone:________________________________

Address:____City:_______________________________________

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

Allergies:____

Medications:____

Comments/Other:____

Health Insurance Data:

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