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: **Holy Childhood of Jesus Activities:, August 1 2022 to July31 2023**

Address of Minor: _____ Phone: _____

Emergency Phone: _____ Date of Birth: _____

Family Physician: _____ Phone: _____

Address: _____ City: _____

List of 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 toe sign the acknowledgement of Receipt of Notice of Privacy Rights that may be presented by the presented by the physician or healthcare 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 treatment physician.

PUBLICITY CONSENT: As parent/guardian of the student(s) named above and below, I understand that promotional pictures & videos (Individual & Group) may be taken. I give permission for my child's picture, name, age, comment, parish, and city to be used for news & promotional materials for the diocese of Gaylord and the Catholic Communities of L'Arbre Croche (Holy Childhood of Jesus Church, Holy Cross, St. Nicholas, and St. Ignatius Churches). These news and promotional materials include but not limited to print, web pages, Facebook, calendars, power point, audio, video, broadcast, etc.

DATE: _____ SIGNED: _____
(Parent/ Guardian)

Name of Minor: _____Relationship to you: _____

Family Physician: _____ Phone: _____

Address: _____ City: _____

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

Allergies: _____

Medications: _____

Comments/Other: _____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____