

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 Faith Formation Activities, June 1, 2019-May 31, 2020**

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 (Holy Childhood of Jesus, Holy Cross, St. Nicholas, and St. Ignatius Churches).

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: _____

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Family Physician: _____ Phone: _____

Address: _____ City: _____

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

Allergies: _____

Medications: _____

Comments/Other: _____

Health Insurance Data:

Company: _____ Policy: _____

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