Child's Grade _____

DIOCESE OF SAGINAW
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.

Reason for which release is intended:

Name of Minor: _____ Relationship to you: _____

Address of Minor: _____ City: _____

Emergency Phone(s): (___) _____ (___) _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

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

_____

_____

Health Insurance Data:
Company: _____ Policy: _____

Group: _____ Contract: _____

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. I understand that some medical providers may not accept this if not notarized.

Date: _____ Signed: _____