

**DIOCESE OF SAGINAW  
MEDICAL TREATMENT RELEASE FORM  
2016-17**

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed physician of any condition, which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Reason for which release is intended: Field Trips

Address of Minor: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Phone(s): (    ) \_\_\_\_\_ (    ) \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_ City: \_\_\_\_\_

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

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**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: \_\_\_\_\_

(Parent or Guardian)