DIOCESE OF SAGINAW
MEDICAL TREATMENT RELEASE FORM
2017-18

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:

_____

_____

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)