MEDICAL TREATMENT AUTHORIZATION FORM

To Whom It May Concern:

As 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.

Student's name____________________________________ Relationship to you:________________________

Address____ Phone:_________________________________

Type of activity or school year for which release is intended:____

PARENTS/LEGAL GUARDIANS

Father	Address	Phone
Mother	Address	Phone

Where parents can be reached when not at home:

Father____

Address Phone

Mother____

Address Phone

Family Physician:______________________________________ Phone:______________________________

Address:____ City:_______________________________

List allergies, medication, or other pertinent comments:

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Health Insurance Data:

Company:____ Policy:_______________________________

Group:____ Contract:____________________________

List a neighbor or close relative who will assume care of your child if you cannot be reached.

Name____ Phone______________________________

Address____ Relationship___________________________

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility.

This authorization form 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.

Date:______________________________________ Signed:_____________________________________

(Parent or Guardian)