2024-2025

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of 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.

FAMILY NAME

Address

City, State, ZIP

Emergency Phone

Emergency Phone

RELIGIOUS EDUCATION
Reason for which release is intended

FAMILY PHYSICIAN

FAMILY PHYSICIAN PHONE

FAMILY PHYSICIAN ADDRES

See back for additional students.

Student Name _____ Grade _____

List **ALLERGIES** to medication, contact, or other pertinent comments:

List any **MEDICATIONS**, learning or physical concerns:

List any custodial concerns:

Student Name _____ Grade _____

List **ALLERGIES** to medication, contact, or other pertinent comments:

List any **MEDICATIONS**, learning or physical concerns:

List any custodial concerns:

HEALTH INSURANCE DATA:

Insurance Policy Group Number _____

Insurance Policy Contract Number _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice 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.

Date: _____

Signed: _____

(Parent or Guardian)

Student Name _____ Grade _____

List **ALLERGIES** to medication, contact, or other pertinent comments:

List any **MEDICATIONS**, learning or physical concerns:

List any custodial concerns:

Student Name _____ Grade _____

List **ALLERGIES** to medication, contact, or other pertinent comments:

List any **MEDICATIONS**, learning or physical concerns:

List any custodial concerns: