

2026-27

St. Michael  
Catholic Community

# MEDICAL TREATMENT 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

Reason for which this Release is Intended: Religious Education

Address

City/State/ZIP

E-Mail

Emergency Phone

Emergency Phone

STUDENT NAME

GRADE

LIST ANY ALLERGIES TO MEDICATION, CONTACT, OR OTHER PERTINENT COMMENTS:

LIST ANY MEDICATIONS, LEARNING OR PHYSICAL CONCERNS:

LIST ANY CUSTODIAL CONCERNS:

STUDENT NAME

GRADE

LIST ANY ALLERGIES TO MEDICATION, CONTACT, OR OTHER PERTINENT COMMENTS:

LIST ANY MEDICATIONS, LEARNING OR PHYSICAL CONCERNS:

LIST ANY CUSTODIAL CONCERNS:



See back for additional students.

## PHYSICIAN INFORMATION

Physician Name

Physician Phone

Physician Address

### 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. I acknowledge that it is my responsibility to submit a new form if any of the above information changes.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

(Parent or Guardian)

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STUDENT NAME

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GRADE

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OR OTHER PERTINENT COMMENTS:

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