



*A foundation of faith and excellence.*

# St. Joan of Arc

CATHOLIC SCHOOL

stjoan.net

## MEDICAL TREATMENT RELEASE FORM 2017/2018

Room # \_\_\_\_\_

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.

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

Reason for which release is intended: \_\_\_\_\_

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

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

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

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

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

\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Data:

Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

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: \_\_\_\_\_

PSI/MedRel/05-94

HAPS-March 2004

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

(Parent or Guardian)