MEDICAL TREATMENT AUTHORIZATION

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 to **CATHOLIC SCHOOLS of GREATER KALAMAZOO - St. Monica Catholic School** only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship to you: _____ Grade _____

Name of Minor: _____ Relationship to you: _____ Grade _____

Name of Minor: _____ Relationship to you: _____ Grade _____

Reason for which release is intended: **EMERGENCIES**

Address of Minor(s): _____ City: _____

Emergency Phone(s): _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medication, contacts, or other pertinent information:

_____

_____

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: _____ Signed: _____
(Parent or Guardian)