Diocese of Grand Rapids

Medical Treatment Release Form

To Whom It May Concern:

As a parent/guardian, I do hereby authorize first aid/medical treatment of my child in the event of an emergency which, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. It is understood that efforts will be made to reach me as soon as reasonably possible.

Name of child: _____ Relationship to you: _____

Grade: _____

Reason for which release is intended: _____

Address of Child: _____ Phone: _____

Emergency Phone: _____ Cell/Pager Number:_____

Family Physician: _____ Phone: _____

Address: _____ City: _____

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

_____

_____

_____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstance in my absence.

I certify that I am the (check one) ☐ custodial parent ☐ legal guardian of the minor child named above, and I agree to the above terms for myself and for my minor child.

Date: _____ Signed:_____
(Parent or Guardian)