

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: \_\_\_\_\_

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

Address of Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

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

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

List allergies, medication, contacts, 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 circumstances 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)

State of \_\_\_\_\_ Subscribed and sworn to before me

County of \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 19 \_\_\_\_\_

\_\_\_\_\_ Notary Public