ST. MICHAEL HIGH SCHOOL
A CHESTERTON ACADEMY

Medical Release & Treatment Form

As parent / guardian, I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____

Parent/Guardian Name: _____ Phone(s): _____

Parent/Guardian Name: _____ Phone(s): _____

Address of Minor: _____

Please list any allergies, disabilities, medications, or other issues or information pertinent to a medical emergency:

_____

_____

EMERGENCY CONTACTS (to be notified in emergency situation when parents are not reachable):

Name: _____ Phone(s): _____

Name: _____ Phone(s): _____

PREFERRED PHYSICIAN for Emergency Treatment:

Physician Name: _____ Phone: _____

Physician Address: _____

HEALTH INSURANCE:

Provider: _____ Policy: _____

Group: _____ Contract: _____

This Medical Release & Treatment Form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Parent/Guardian Signature: _____ Date: _____