Catholic Diocese of Saginaw
St. Jude Thaddeus Parish, Essexville, MI
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 only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship to you:_____

Reason for which release is intended: *Field Trip/experience off parish grounds or during a supervised event on parish grounds during which parents are not present and in the event of an emergency situation and medical treatment is warranted.*

Address of Minor: City:_____

Emergency Phone(s): (____) _____ (____) _____

Family Physician: _____Phone:_____

Physician Address: _____City:_____

List allergies, medication, contacts, 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: Signed:_____(Parent or Guardian)_____