MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As a 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. The authority is granted only after a reasonable effort has been made to reach me.

Name of Minor:_____ Relationship to you:_____
**Use back of sheet for more than one.*

Reason for which release is intended: **Cross in the Woods- Faith Formation Activities School Year/_____**

Address of Minor: _____ Phone: _____

Emergency Phone:_____ Date of Birth:_____

Family Physician:_____ Phone: _____

Address: _____ City: _____

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

Allergies:_____

Medications:_____

Comments/Other:_____

Health Insurance Data:_____

Company:_____Policy:_____

Group:_____Contract:_____

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice of 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.

PUBLICITY CONSENT: As parent/guardian of the student named above or back of sheet, I understand that promotional pictures & videos (individual & group) may be taken. I give permission, without remuneration, for my child's picture, name, age, comments, parish and city to be used for news and promotional materials (including, but not limited to, print, bulletins, web pages, Facebook, calendars, power point, audio, video, broadcast, etc.) for the Diocese of Gaylord and Cross in the Woods Church.

Date:_____ Signed: _____
(Parent or Guardian)

Please return your completed form to the Faith Formation Office
at 7078 M-68, Indian River, MI 49749

Name of Minor: _____ Relationship to you: _____

Family Physician: _____ Phone: _____

Address: _____ City: _____

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

Allergies: _____

Medications: _____

Comments/Other: _____

Health Insurance Data:
Company: _____ Policy: _____

Group: _____ Contract: _____

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