MEDICAL TREATMENT AUTHORIZATION AND RELEASE FORM

As parent/guardian, I authorize a school representative, in an emergency or urgent medical circumstances, to authorize the treatment by a licensed healthcare provider 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. I further authorize transportation of the minor by emergency medical services as deemed necessary by the attending healthcare provider or emergency personnel.

Name of Minor: _____ Relationship to you: _____

Date of Birth: _____

Reason for which release is intended: St Thecla Religious Education - 2026-2027

Address of Minor: _____ City: _____

Emergency Phone(s): _____

Child's Physician: _____ Phone: _____

Physician Address: _____ City: _____

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

_____

_____

Health Insurance Data:

Company: _____ Policy: _____

Group No: _____ Contract: _____

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility. In case I cannot be reached, I authorize the healthcare provider to discuss the treatment plan with the school representative and authorize the release of the minor's health information to the school representative as necessary to coordinate care and respond to the emergency.

This authorization is completed and signed voluntarily with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician. I acknowledge that it is my responsibility to submit a new form if any of the above information changes.

Date: _____ Signed: _____
(Parent or Guardian)

_____ _____
Best Contact (cell phone(s), email) Parent Printed Name