Medical Treatment Authorization
St. Monica Religious Education Program
2020-2021

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. This medical treatment release is for all St. Monica Parish Religious Education classes and events.

Name of Minor _____ Relationship to you _____

Address of Minor _____

Emergency Phone(s) _____ _____

Family Physician _____

Phone _____ Hospital Preference _____

Physician Address _____ City, State, Zip _____

Family Health Insurance company _____

Policy # _____ Group # _____ Contract # _____

List Allergies, medications, contacts, or other pertinent comments _____

_____

_____

I further authorize the person who presents the minor to sign the Acknowledgment 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)

Print Parents/Guardians Names _____

Best telephone numbers to reach you both in an emergency.

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