Emergency Medical Treatment Release Form

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment of 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 undo discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Student's name:_____ Relationship to you:_____

Address:_____ Phone:_____

Type of activity or school year for which release is intended:_____

PARENT/LEGAL GUARDIANS

_____

Father Address Phone

_____

Mother Address Phone

Where parents can be reached when not at home:

Father_____

Address Phone

Mother_____

Address Phone

FamilyPhysician:_____Phone:_____

Address:_____City:_____

List allergies, medication, or other pertinent comments:

_____

_____

Health Insurance Data:

Company:_____Policy:_____

Group:_____Contract:_____

List a neighbor or close relative who will assume care of your child if you cannot be reached:

Name:_____Phone:_____

Address:_____ Relationship:_____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date:_____Signed:_____

Attention Parents: This form should be notarized.

Some medical facilities will only provide treatment if the signature is notarized.

Notary to complete:

State of: This_____day of_____,_____

County of: _____Notary Public

<u>This form is to be completed by the parent/guardian who has signed the permission slip</u>

NAME OF TEEN THE FOLLOWING INFORMATION APPLIES TO:

_____

- With respect to the information you have listed on the Medical Treatment Release Form, section –"List allergies, medication, or other pertinent comments", please explain if these are medications your teen is allergic to OR currently taking.

- If they are being taken at the time of the event please describe dosage, any side effects we should be aware of, eating/drinking instructions, etc. Also in this space please disclose any health issues we should be aware of with your teen:

- Please CIRCLE any item(s) below that you give St. Mary of the Hills permission to administer to your teen upon their request. We will administer them in accordance with the label directions. If you have specific instructions on administration of these medications, please disclose them on this sheet

Tylenol
Extra-Strength Tylenol
Advil
Ibuprofen
Aleve
Tums
Rolaids
Mylanta
Neosporin
Pamprin or Midol

_____Initial Here

- List any other information I may need to know here:

PLEASE NOTE: It is your responsibility to notify St. Mary of the Hills Youth Minister of anything changes!

Signature of Parent/Guardian_____Date_____

St. Mary of Hills Catholic Church
2675 John R.
Rochester Hills, MI 48307
(248) 853-5390