ST. MICHAEL ACADEMY

MEDICAL TREATMENT RELEASE FORM 2018-19

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. 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: student at St. Michael Academy and any activities related to SMA

Address of Minor: _____

In case of an accident or serious illness the school will first contact a parent.

PERSONS OTHER THAN PARENT TO BE NOTIFIED IN EMERGENCY SITUATION WHEN PARENT IS NOT AVAILABLE:

EMERGENCY CONTACT NAME: _____

Preferred Phone Number: (Cell? Home? Work?)_____

Other: _____

Backup Contact: Name: _____

Preferred Phone Number: _____

PHYSICIAN PREFERRED FOR EMERGENCY TREATMENT:

Family Physician: _____ Phone: _____

Address: _____

List allergies, medication, contacts or other pertinent comments:

_____

_____

_____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

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.

THIS FORM MUST BE NOTARIZED.

Signed: _____ Date: _____
(Parent or Guardian)

State of: _____ County of: _____

Subscribed and sworn to before me _____ _____
(printed name of notary) (signature of notary)

This _____ day of _____ 20____