# Diocese of Grand Rapids

## Medical Treatment Release Form

To Whom It May Concern:

As a parent/guardian, I do hereby authorize first aid/medical treatment of my child in the event of an emergency which may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. It is understood that efforts will be made to reach me as soon as reasonably possible.

Name of child:____________________________________Relationship to you:_____________

Reason for which release is intended:_____________________________________________

Address of Child:___________________________________________Phone:_______________

Emergency Phone:_____________________________________________________________

Family Physician:_________________________________________Phone:________________

Address:_________________________________________________City:_________________

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.

I certify that I am the (check one)_______custodial parent (or) ______legal guardian of the minor child named above, and I agree to the above terms for myself and for my minor child.

Date:__________________________Signed :__________________________________________

(Parent or Guardian)