

MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As a parent/guardian I do here by 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: *National Catholic Youth Conference*

Address of Minor: _____ Phone: _____

Emergency Phone: () - Cell () -

Family Physician: _____ Phone: _____

Address: _____ City: _____

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

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

This release from 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.

Date: _____ Signed: _____
(Parent/Guardian Signature)

State of: _____ County of: _____
Subscribed and sworn to before me

This _____ day of _____

_____ Notary Public