

MEDICAL TREATMENT RELEASE FORM

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: _____

Address of Minor: _____ Phone: _____

City: _____ State: _____ Zip: _____

Emergency Phone: _____ Date of Birth _____

Family Physician: _____ Phone: _____

Address: _____ City: _____ State: _____

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

Date: _____

Signed: _____

(Parent or Guardian)

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State of: \_\_\_\_\_

Subscribed and sworn to, before me this

County of: \_\_\_\_\_

\_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
(Notary Public for the State of Michigan)

My Commission Expires \_\_\_\_\_

County of \_\_\_\_\_