



# HOLY NAME CATHOLIC SCHOOL

J. M. J.



## Health and Emergency Medical Treatment Release

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed medical doctor in an emergency that, in the opinion of the attending physician, may endanger my child's life, cause a disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to contact me.

Name of Minor: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Reason for which release is intended: Medical emergency at Holy Name Catholic School or during off-site, school-sponsored events in my absence.

Address of Minor: \_\_\_\_\_ City: \_\_\_\_\_

Emergency Phone(s): \_\_\_\_\_ or \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_ City: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Health Insurance Data:

Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

*I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility. This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_