This medical form will be kept on file from ***JUNE 2023 through August 2024*** **Youth Group, Confirmation & Middle School Ministry :**

Parents are responsible to notifying the office with any changes

MEDICAL TREATMENT AUTHORIZATION FORM

To whom it may concern:

As parent/guardian, I do hereby authorize the treatment by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

Student's Name: _____Relationship to you: _____

Address: _____

Type of activity or school year for which release is intended: **YOUTH GROUP EVENTS 2014-2015**
PARENT/LEGAL GUARDIANS

_____
Father Address Phone

_____
Mother Address Phone

Where parents can be reached:

Father: _____
Address Phone

Mother: _____
Address Phone

Family Physician: _____Phone: _____

Address: _____City: _____

List of allergies, medications, or pertinent comments:

_____

Health Insurance Data:

Company: _____ Policy: _____
Group: _____ Contract: _____

List a neighbor or close relative who will assume care of your child if you cannot be reached.

Name: _____ Phone: _____
Address: _____ Relationship: _____

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility. This authorization form 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.

Date: _____ Signed: _____
(Parent or Guardian)

PLEASE COMPLETE BOTH SIDES

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ADDITIONAL MEDICAL INFORMATION

Father's Cell phone: _____ Mother's Cell phone: _____

Father's Office phone: _____ Mother's Office phone: _____

Please check and initial those items below that we may give to your child without contacting you. Note that we will not give your child any of the following unless you have checked and initialed the item/s below or given us written authorization (no verbal permission).

_____Tylenol_____ _____Advil_____ _____Motrin_____ _____Aleve_____

(Check) (Initial) (Check) (Initial) (Check) (Initial) (Check) (Initial)

_____Benadryl_____

(Check) (Initial)

If your child had any medical condition or allergies such as asthma, seizures, food allergies, environmental allergies or any others that may cause a trigger reaction, please list the severity. Please identify triggers that will help us keep your child safe, list warning signals, and steps you would like us to take in case of an episode:

_____
_____
_____
_____
_____

Please tell us any other information you would like us to know about your child. PLEASE KNOW THAT ALL AND ANY INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

_____
_____
_____
_____

_____ _____
(Parent/Guardian signature) (Date

PLEASE COMPLETE BOTH SIDES