This medical form will be kept on file from ***JUNE 2024 through August 2025***
Youth Group, Confirmation & Middle School Ministry :

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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Parents are responsible to notifying the office with any changes

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:

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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.

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_____________________________________ _________________________

(Parent/Guardian signature) (Date

PLEASE COMPLETE BOTH SIDES