



GRADES K-8  
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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 the release is intended: \_\_\_\_\_

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

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

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

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

List allergies, medication, contact, 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.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Parent or Guardian)

IMMACULATE HEART OF MARY-ST. CASIMIR CATHOLIC SCHOOL CHALLENGES STUDENTS TO DISCOVER GOD'S GIFTS SPIRITUALLY, INTELLECTUALLY, SOCIALLY AND PHYSICALLY WITHIN A COMMUNITY THAT NURTURES, HONORS AND RESPECTS THE UNIQUE PERSON.