MEDICAL TREATMENT RELEASE FORM 2020-2021

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of 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.

Name of Minor: _____ Relationship to you _____

Reason for which release is intended: _____

Address of Minor: _____ City: _____

Emergency Phone(s): _____ Emergency Contact Person: _____

Family Physician: _____ Phone: _____

Physician Address: _____ City: _____

List allergies, medication, contract, 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.

Date: _____ Signed: _____
(Parent or Guardian)

PSI/MedRel/05-94
HAPS-March 2004

In the event that medication needs to be dispensed, the *Release for Dispensing of Medication* form on the back needs to be completed.

OVER

(If applicable)

RELEASE FOR DISPENSING OF MEDICATION

We, the undersigned parent and/or guardian of:

_____ _____ Born _____/____/_____
(Student's Name) (Grade/Room #) Mo Day Yr

do hereby sign and execute this release on behalf of us and on behalf of our minor son/daughter/ward.

NAME OF MEDICATION:_____

DOSE:_____

TIME TO BE GIVEN:_____

DURATION:_____

ATTACH DOCTOR'S NOTE REGARDING EMERGENCY CARE PLAN AND ADMINISTRATION OF MEDICATION.

☐ **Check here, if this release is for a metered dose asthma inhaler, insulin pump or epinephrine auto-injector, which the student will possess and use at his/her own discretion in school or at school activities. The physician and parents/guardian signature below apply to the inhaler, insulin pump or epinephrine auto-injector possession and use by students as permitted in Public Act 10 – Revised School Code.**

_____ _____ _____
(Doctor's Signature) (Please Print Name) (Date)

___**(**_____**)**_____
(Phone Number)

We hereby waive any liability whatever to the school or the Archdiocese of Detroit or any of its personnel, that might occur as the result of giving said medication in the indicated dosage at the time requested to our minor son/daughter/ward.

PARENT/GUARDIAN _____
(Signature)

_____
(Print Name)

DATE _____

OVER