

Aldersgate United Methodist Church
2206 Airfield Lane, Midland, Michigan 48642 (989)631-1151
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 a medical 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: _____ Birthdate: _____ Relationship to You: _____

Purpose & Date(s) Authorization Is Intended: _____

Address of Minor: _____

(City/State)

(Zipcode)

Family Physician: _____ Phone: _____

Address: _____ City/State/Zipcode _____

My son/daughter is allergic to the following:

My son/daughter has the following medical condition:

Medicines my child is now taking:

HEALTH INSURANCE DATA:

Insurance Company: _____ Subscriber Name: _____

Policy Number(s): _____

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.

(Signature of parent or guardian)

(Date)

(Print your name)

(Address)

(Home Phone)

(Work Phone)

(Cell Phone)

Alternate Emergency Contact Person:

(Name)

(Phone)

(Cell Phone)