RETURN THE FIRST DAY OF SCHOOL – ONE FOR EACH CHILD AT CABRINI

MEDICAL TREATMENT AUTHORIZATION
2017-18 School Year

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment by a qualified and licensed physician of any condition that, 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. I also authorize treatment by the Parish/School nurse (RN) of any condition that is deemed necessary and appropriate.

Name of Minor:_____ Grade:_____ Relationship to you: _____

Complete Address of Minor: _____

Emergency Phone(s):_____

Family Physician:_____ Phone: _____

Physician's Complete Address:

_____

List allergies, medications, contacts or other pertinent comments:

_____

_____

Health Insurance Data:

Company:_____ Policy: _____

Group:_____ Contract: _____

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 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.

Parent/Guardian Name (printed):_____

Parent/Guardian signature: _____ Date: _____