BAY AREA CATHOLIC SCHOOLS
MEDICAL TREATMENT AUTHORIZATION

To Whom It May Concern:

As a 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.

Name of Minor:______________________________ **Relationship to you**: ________________

Address of Minor:__________________________________ **City**:________________________

Emergency Phone(s): (____)_________________________ (____)______________________

Family Physician:__________________________________ **Phone**:______________________

Physician Address:__________________________________ **City:**______________________

List all allergies, medication, contacts, conditions or other pertinent comments (i.e., asthma, diabetes, ADHD, ODD. etc...):

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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 physician.

Date:_______________________ Signed:____
(Parent or Guardian)

*** Valid for one year**

(6/11)