ST. MICHAEL ACADEMY

Medical Release & Treatment 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 of delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship to Minor: _____
Reason for which Release in intended: Student at St. Michael Academy and any activities related to SMA.
Address of Minor: _____
In case of an accident or serious illness the School will first contact the parent.

PERSONS OTHER THAN A PARENT TO BE NOTIFIED IN AN EMERGENCY SITUATION WHEN PRESENT IS NOT AVAILABLE:

EMERGENCY CONTACT NAME: _____ CELL: _____
WORK: _____ HOME: _____

BACKUP CONTACT NAME: _____ PHONE: _____

PHYSICIAN PREFERRED FOR EMERGENCY TREATMENT:

FAMILY PHYSICIAN: _____ PHONE: _____
ADDRESS: _____
List allergies, medication, contacts 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.

THIS FORM MUST BE NOTARIZED

Date: _____ **Signed:** _____
(Parent or Guardian's Signature in front of Notary)

State of _____ **Subscribed and sworn to before me** _____
(printed name of Notary Public)
_____ Notary Expires: _____
(signature of Notary Public

County of _____ This _____ day of _____, _____