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 reasonable effort has been made to reach me.

Name of minor _____ Adviser _____

Relationship to me _____

Reason for which release is intended- Junior Retreat, Clarkston, MI

Address of minor _____

Emergency phone (s) _____

Family Physician _____ Phone_____

Physician address_____ City _____

List: allergies, medications, contacts or other pertinent comments. Make sure your daughter has her medicine with her including: epipen, insulin, inhaler, and/or medicine. AND IT MUST BE NOTED ON THIS FORM.

Health Insurance Data:

Company:_____ Policy #:_____

Group #_____ Contract _____

I further authorize the person who presents this minor to sign Acknowledgement of Receipt of Notice Privacy Rights that may presented by the physician or healthcare facility.

This authorization is complete 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 Signature _____ Date _____