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-KAIROS 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 _________________