



A Medical Treatment Release Form

To Whom It May Concern:

As a parent/guardian, I do hereby authorize the treatment of my child by a qualified and licensed physician for 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 child _____

Relationship to you _____

Reason for which release is intended:

For attendance at Dominican Faith Camp, July 8-10, 2018

Address of minor _____

City _____ State _____ Zip _____

Emergency Phone (s) _____

Family Physician _____

Family Physician Phone _____

Family Physician Address & City _____

List allergies, medication, contact or other pertinent comments:

(over)

Please send form to:

Sister Teresa Marron - 1237 West Monroe St. Springfield, IL 62704

Questions? Contact Sr. Teresa Marron: srteresa@spdom.org - 708.207.1874

www.springfieldop.org

Dominican Faith Camp Medical
Treatment Release Form Page 2



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.

Date _____
Parent or guardian

Please send form to:
Sister Teresa Marron - 1237 West Monroe St. Springfield, IL 62704
Questions? Contact Sr. Teresa Marron: srteresa@spdom.org - 708.207.1874
www.springfieldop.org