



Prince of Peace Youth Ministry Program  
315 W Center St, Linwood, MI 48634, 989-697-3100

**MEDICAL TREATMENT RELEASE FORM**

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 if delayed. This authority is granted only after a reasonable effort has been made to reach me.

**Family Information**

Reason for which release is intended: Youth Ministry Events

Address of Minor (s): \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Name of minor: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

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Please list any medical conditions: allergies, medication, contacts, or other concerns below (Make sure to indicate about which child you are referring):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian)

**MEDIA RELEASE AUTHORIZATION**

Prince of Peace Parish will not photograph, videotape and/or voice tape individuals in its programs without consent. This form allows you to make known your wishes. Please check the appropriate box below.

**I do give permission** for the personnel of Prince of Peace Parish to photograph, videotape and/or voice tape my child/children (or allow area news reporters to do the same) for any purpose.

**I do not give permission** for the personnel of Prince of Peace Parish to photograph, videotape and/or voice tape my child/children (or allow area news reporters to do the same) for any purpose.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_