LIGHT OF CHRIST ACADEMY
Montessori and Classical Education
12648 East D Ave • Augusta MI 49012 • 269.203.6808
office@lightofchristacademy.org • lightofchristacademy.org

Medical Treatment Authorization

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 a reasonable effort has been made to reach me.

Mother's Name: ______________________________ Father's Name: ______________________________

Address of Minor: ___________________________________ City: _____________________Zip: ___________

Mother's Cell _________________________________ Father's Cell _________________________________

Email: ____

Name of Minor: __________________________________ Relationship to you: _________________________

Reason for which release is intended: Light of Christ Academy

Family Physician: ________________________________ Phone: ___________________________________

Physician's Address: ____________________________ City: _______________________________________

List allergies, medications, contacts or other pertinent comments:

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Good Health Statement

My child is in good health and immunizations are up-to-date and the immunization record or waiver is on file at Light of Christ Academy and updated annually. (400.8143 (8))

Signed: ____ Date _________________________

Parent or Guardian

Health Insurance Date

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.

Signed: ____ Date _________________________