Prince of Peace Roman Catholic Church

4300 Walnut Lake Road. West Bloomfield, MI. 48323 www.princeofpeacecatholic.church

Parent Information/Medical Treatment Authorization Form

Father's Name:

Address (If different than teen's):

Home Phone #: Cell #:

E-mail: Religion:

I am interested in being an Adult Leader for Youth Group (circle one): **(*)** Yes No

I am registered in the Parish? (circle one) Yes No

Mother's Name:

Address (If different than teen's):

Home Phone #: Cell #:

E-mail: Religion:

I am interested in being an Adult Leader for Youth Group (circle one): **(*)** Yes No

I am registered in the Parish? (circle one) Yes No

NOTE: (*) Requires Protecting God's Children Certification AND criminal Background Check.

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Parent Information/Medical Treatment Authorization Form

To Whom It May Concern:

As parent/guardian of: _____, I do hereby authorize the treatment of 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.

Father and/or Mother signature Date:

Family Physician: Phone #:

Address:

Health Insurance Data: Company: Policy #

Emergency Name and Phone # (If we can't reach you)

List Allergies, medication or other pertinent comments if necessary: