ST. PATRICK'S PARISH

EMERGENCY MEDICAL AUTHORIZATION FORM FOR TEENS UNDER 19
(Only needs to be filled out once each year.)
Child's Name:_____
Birthday:_____

Purpose: This form enables parents to authorize the provision for emergency treatment for children who become ill or injured while at a youth event. Consent to seek such treatment is granted specifically to official adult representatives and chaperones of St. Patrick Parish, and if needed, to be evaluated, diagnosed, treated, and/or medicated in accordance with standard medical practice by licensed medical personnel.

I relieve St. Patrick Parish, the adult leaders, and the Archdiocese of Anchorage-Juneau from all responsibility and consequences that may arise as the result of this treatment.

I will not hold the chaperones, or representatives associated with the even responsible in the even of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling such treatment.

TO GRANT CONSENT

NAME OF PARENT/GUARDIAN:_____
ADDRESS:_____
MOTHER'S CELL PHONE:_____
FATHER'S CELL PHONE:_____
REGULAR PHYSICIAN:_____
PHYSICIAN'S PHONE NUMBER:_____

In the event that reasonable attempts to contact the above named have been unsuccessful, I hereby give my consent for any treatment deemed necessary for my child named on this form by medical personnel at the nearest medical facility.

SIGNATURE OF PARENT/GUARDIAN:_____
DATE:_____

FAMILY INSURANCE COMPANY:_____
POLICY #:_____

If the parents cannot be reached, the alternate person to notify in the even of injury or illness is:

ALTERNATE CONTACT PERSON:_____PHONE #:_____

CHILD'S MOST RECENT MEDICAL HISTORY:

ALLERGIES:_____
MEDICATIONS:_____
PHYSICAL IMPAIRMENTS:_____
VACCINATIONS OR BOOSTER SHOTS *IN THE PAST YEAR*

_____
SERIOUS ILLNESS OR ACCIDENTS *IN THE PAST YEAR*

_____
OTHER PERTINENT INFORMATION:

_____