

## Part I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room Phone \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medication being taken and any physician impairments to which a physician should be alerted - Does your child have any unusual health conditions? \_\_\_\_ Yes \_\_\_\_ No

If yes, please check

\_\_\_\_ Asthma \_\_\_\_ Bee sting allergy \_\_\_\_ Epilepsy \_\_\_\_ Sight impairment \_\_\_\_ Wears glasses

\_\_\_\_ Hearing problem \_\_\_\_ Hearing aide \_\_\_\_ Diabetes (\_\_\_\_ Mild \_\_\_\_ Severe) \_\_\_\_ Heart

\_\_\_\_ Allergy (list) \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child \_\_\_\_\_

## Part II: Refusal to Consent

I do NOT give my consent for the emergency medical treatment of my child. In the even of illness or injury requiring emergency treatment, I wish the Church authorities to take the following action:

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

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child \_\_\_\_\_



**Emergency Medical Authorization Form  
& Information Regarding Legal Custody  
St. Joseph Parish PSR Program**

Date \_\_\_\_\_

Student \_\_\_\_\_ Grade \_\_\_\_\_

Address of child's residence \_\_\_\_\_ Phone \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under Church authority, when parents/guardians cannot be reached and to ensure the child's safety and well being.

Child lives with:

- \_\_\_\_\_ both natural parents
- \_\_\_\_\_ natural mother, step/adoptive father
- \_\_\_\_\_ natural father, step/adoptive mother
- \_\_\_\_\_ only mother
- \_\_\_\_\_ only father
- \_\_\_\_\_ grandparents (with legal custody)
- \_\_\_\_\_ other relative (with legal custody)

Relationship: \_\_\_\_\_

other

Please explain: \_\_\_\_\_



Residential Parent or Guardian

Mother's Name \_\_\_\_\_ Sunday Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Sunday Phone \_\_\_\_\_

Other's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Sunday Phone \_\_\_\_\_

Is there a court order (or pending order) affecting the custody and/or residency of the child? \_\_\_\_\_

If so, please attach a copy of the page of the court decision bearing those sections referring to visitation rights and contacts with the school/PSR. This copy should include any and all modifications made as of the date of registration of the child in this PSR program. It is also the responsibility of the parent to inform the Director of Religious Education of any subsequent modifications during the child's tenure in the Parish Religious Education Program.

Non-residential parent:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
City, State Zip

Does the non-residential parent have visitation rights? \_\_\_\_\_

Does this child spend alternating weekends with the non-residential parent that will result in absence from PSR? \_\_\_\_\_

Comments:

**OVER - Part I or Part II of the Reverse Side Must Also be Completed**