Photo Consent Release Form

☐ I grant, St. Mary Church the right to take photographs/videos of my child. I agree that St. Mary Church may use photographs for any social media publications or website content.

☐ I ***do not*** grant, St. Mary Church the right to post any pictures of my child to social media publications or website content.

Child (Fill out one form for each child)_____

Parent Signature_____

CCD Medical Form 2025-2026

Emergency Medical Authorization Form

Student Name _____

Address _____

Telephone _____

The purpose of this form is to enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents/guardians can not be reached or time is of the essence.

Confidentiality notice:
I would like to meet with my child's teacher or Director of Catechesis to provide information concerning special situations or medications that my child needs or uses. I understand this additional information is confidential and will be used only to help create optimum conditions, as much as possible, for my child to succeed in the evening classroom setting.

☐ *Please check here if the statement above applies.*

Residential Parent/Guardian

Mother's Name _____ Phone _____

Father's Name _____ Phone _____

Emergency Contacts during CCD time (will call in the order given)

Name (relationship) _____ Phone _____

Name (relationship) _____ Phone _____

(See Reverse Side)

Side 2: Please complete Part I OR Part II

Part I TO GRANT CONSENT

I hereby give consent for the following medical care provider and local hospital to be called in the event reasonable attempts to contact me or a family relative have been unsuccessful. I hereby give my consent for (1) the administration of any treatment necessary by the named 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.

Physician _____ Phone _____

Dentist _____ Phone _____

Local Hospital _____ Phone _____

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted are noted here:

_____

Signature _____ Date _____
(Parent or Guardian)

Part II
REFUSAL to Grant Consent

I DO NOT give consent for emergency medical treatment of my child in the event of illness or injury requiring emergency treatment. I wish the administrator to take the following action:

_____

_____

_____

Signature _____ Date _____
(Parent or Guardian)