Saint Bernadette Parish

PARISH SCHOOL OF RELIGION

2025-26 Emergency Medical Authorization Form

(A separate form must be completed for each registered child)

Form must be completed & turned in prior to first day of PSR.

Child's Name: _____
Last *First* *Middle*

Address: _____

City: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

RESIDENTIAL PARENT/GUARDIAN

Mother's Name: _____
First *Last*

Father's Name: _____
First *Last*

Other's Name: _____
First *Last*

Parent E-Mail: _____@_____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill while attend PSR classes when parents or guardians cannot be reached.

If I cannot be contacted and it is advisable to send my child home due to minor illness or injury, my child can be released to the following:

Name: _____ Relationship: _____
First *Last*

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

_____

_____

_____

_____

Part A or B must be completed.

PART A: TO GRANT CONSENT

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

Physician: _____ Phone: _____
First *Last*

Dentist: _____ Phone: : _____
First *Last*

Medical Specialist: _____ Phone: : _____
First *Last*

Local Hospital: _____ Phone: _____
Name

Medical Insurance Provider: _____ No.: _____
Name

In the event reasonable attempts to contact me as parent/guardian have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by:

Dr. _____ (preferred physician), or Dr. _____

_____ (preferred dentist) or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the

child to _____ (preferred hospital) or any hospital that is 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.

Parent Signature: _____ Date: _____

Part B: Refusal of Consent

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the program administrator to take the following action:

_____

Parent Signature: _____ Date: _____