

**St. Agnes Church
Religious Education - PSR**

Emergency Medical Authorization

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.

Student's name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

Custodial Parent (s) or Guardian(s):

Mother: _____ Phone/Cell Phone _____

Father: _____ Phone/Cell Phone _____

Other Contact: _____ Phone/Cell Phone _____

Address: _____ Relationship: _____

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Phone: _____

Health Ins. Carrier _____ Name of policy holder: _____

IMPORTANT: Specific instructions needed and updated yearly. Facts concerning the child's medical history, including allergies, medications being taken and any physical impairments to which a physician or church personnel should be alerted must be listed below. If the student requires medication during PRS time please contact the Religious Ed. Office at (330)682-2611 to make appropriate arrangements..

(Signature of parent or Guardian)

Date

OVER

PART I OR PART II MUST BE COMPLETED

Part I: To Grant Consent

In the event reasonable attempts to contact me and other parties listed above have been unsuccessful, I hereby give my consent for:

- 1. the administration of any treatment deemed necessary by listed medical care providers, or in the event the designated provider is not available, by any other licensed provider and;
- 2. the transfer of the child to the designated hospital or any hospital reasonably accessible (including consent authorizing emergency surgery following consensus of two appropriately licensed providers).

My signature confirms my understanding of this form and the completeness of information required.

Signature of parent or guardian Address Date

Do Not complete Part II if you completed Part I

Part II: Refusal to Consent

My signature confirms my understanding of this form and the completeness of information required. 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 church personnel to take the following action as they are reasonably able to do so:

Signature of parent or guardian Address Date