

Emergency Medical Release for Treatment - Saint Richard Youth Ministry

The following is to be used in case of the need for Emergency Medical Treatment. The more information available, the quicker and easier it is to obtain treatment. Information won't be used for ANY other purpose. Please sign ONLY the Authorization OR the Refusal. DO NOT SIGN BOTH PLACES.

Emergency Medical Authorization

In the event reasonable attempts to contact me _____ at _____
(Name of Parent) (Phone Number)

or _____ at _____ have been unsuccessful, I
(Name of Other Parent or emergency contact and relation) (Phone Number)

hereby give my consent for the administration of any treatment deemed necessary by:

Dr. _____ at _____ or Dr. _____ at _____,
(Name of Preferred Physician) (Phone Number) (Name of Preferred Dentist) (Phone Number)

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist;

and, the transfer of my child to _____ or any hospital that is reasonably
accessible. (Name of preferred hospital)

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history, including allergies, medications being taken, information to which a physician should be alerted: _____

Child's Name: _____ Date of Birth: _____

Policy Holder: _____ Insurance Name: _____

SSN of Policy holder: _____ SSN of Child: _____

Signature of Parent/Guardian (Participant if 18 or older) Date

Please Print Name of Parent/Guardian (Participant if 18 or older)

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REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of my son/daughter. In the event of illness or injury requiring emergency treatment, I wish the youth ministers to take no action.

Signature of Parent/Guardian (Participant if 18 or older) Date

Please Print Name of Parent/Guardian (Participant if 18 or older)