

Acquire the Fire Youth Group



MEDICAL AUTHORIZATION FORM for 2012-2013

Medical Release to Grant Consent

I hereby request and authorize the St. Anthony of Padua parish, youth ministry and the Diocese of Cleveland, Ohio, hospitals, licensed medical provider, and their agents and employees to have access to the information contained in this form and to provide all medical care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act for my child.

Signature of Parent/Legal Guardian

Printed Name of Parent/Legal Guardian

Date

Refusal to 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 parish authorities to take no action or to:

Signature of Parent or Legal Guardian

Printed name of Parent or Guardian

Date

Release of Activity Liability Statement

I hereby release the St. Anthony of Padua parish, youth ministry and the Diocese of Cleveland from the responsibility of any liability involving injury or accident to my child participating in the activity listed above on the given date listed. I as the parent or

guardian of the participant listed above, hereby release St. Anthony's of Padua parish, youth ministry and the Diocese of Cleveland from the accident or injury causing circumstances and will accept full responsibility for my child's actions.

Signature of Parent or Legal Guardian

Printed name of Parent or Guardian

Date

EMERGENCY CONTACT INFORMATION

Parent/Guardian Name(s) _____

Phone Numbers _____ Alternate Phone _____

Street Address _____ City _____ Zip _____

Other Emergency Contact

Name(s) _____

Relationship to Participant _____

HEALTH CARE INFORMATION

Participant Name _____

Physician _____ Phone Number _____

Medical Insurance Company _____ Policy/Group Number _____

Name of Policy Holder _____

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

