2018-19 EMERGENCY MEDICAL RELEASE FORM and PERMISSION FORM
ST. MICHAEL YOUTH MINISTRY

A current emergency medical form must be on file in order to participate in St. Michael the Archangel Parish Youth Ministry events. Forms are kept on file for one year and must be updated annually at the beginning of the academic year. Please return completed forms to:

St. Michael the Archangel Parish, attn. Alyssa Brown
750 Bright Road, Findlay, OH 45840

YOUTH NAME_____ BIRTHDATE _____ SCHOOL _____ GRADE _____

ADDRESS _____CITY_____ ZIP _____ HOME PHONE _____

YOUTH CELL PHONE _____ YOUTH EMAIL _____

In an emergency, St. Michael Youth Ministry will FIRST attempt to contact the Parent/Guardians:

MOTHER'S NAME _____ EMAIL_____

CELL PHONE _____ WORK PHONE _____

FATHER'S NAME _____ EMAIL _____

CELL PHONE _____ WORK PHONE _____

If St. Michael Youth Ministry CANNOT reach the above, please list other person(s) who may be notified and to whom your child may be released:

EMERGENCY CONTACT #1 _____

CELL PHONE _____ WORK PHONE _____

EMERGENCY CONTACT #2 _____

CELL PHONE _____ WORK PHONE _____

CONSENT OR REFUSAL TO CONSENT TO EMERGENCY TREATMENT

☐ **PLEASE INITIAL BOX AND COMPLETE SECTION FOR GRANTING CONSENT FOR TREATMENT:**
In the event that reasonable attempts to contact PARENT/GUARDIANS were made, I/we do hereby consent for:

The administration of any treatment deemed necessary by:

- (1) Dr. _____ (preferred physician) at the following phone# _____

  Dr. _____ (preferred dentist) at the following phone# _____

  Dr. _____ (preferred medical specialist) at the following phone# _____

Or in the event the preferred physician or dentist is not available, consent is given for treatment by any licensed physician or dentist and:

- (2) The transfer of the child to _____ (preferred hospital) or 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.

-form continues on reverse side

The following are facts concerning the child's medical history including allergies, medications being taken, medical conditions and any physical impairment to which the physician(s)/dentist(s) should be alerted:

EXISTING MEDICAL CONDITIONS: _____

_____

MEDICATIONS: _____

_____

ALLERGIES: _____

_____

MEDICAL INSURANCE INFORMATION:
Name of Policy Holder_____ Insurance Carrier_____

Policy Number_____ Group Number_____

☐ **PLEASE INITTIAL BOX IF YOU REFUSE TO CONSENT TO EMERGENCY TREATMENT**
I/we do not give consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment I/we wish that St. Michael Youth Ministry program take no action or to:

_____

_____

_____

_____

PERMISSION TO PARTICIPATE IN YOUTH MINISTRY PROGRAMMING AND ASSUMPTION OF LIABILITY

By signing as a parent or legal guardian, I give_____my **permission** to participate in St. Michael Youth Ministry activities and trips. I agree to assume full responsibility for bodily injury, loss of personal property, and expenses thereof, if they should occur as the result of my youth's negligence. In consideration for my youth's participation, I further agree not to hold St. Michael Church, the Coordinator of Youth Ministry, or Youth Ministry Volunteers to claims of ordinary negligence. I also understand and agree that photos or videos taken at functions sponsored by St. Michael Parish may be posted on the parish website and social media accounts.

X_____Date_____
(Signature of parent or **legal** guardian)

Address: _____