Medical Treatment Authorization

As a parent/guardian, I do hereby authorize the treatment of my minor child/children listed below by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

I further authorize the person who presents the minor to sign the Acknowledgment of Receipt of Notice of Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician due to injury or illness sustained during religious education classes, testing, and/or activities by SS. John & Bernard Parish Religious Education Program.

Names of Children **List of Allergies, Medications, or Other Pertinent Information**

(If your child has a learning disability that requires an IEP in their public school setting, please indicate that here.)

_____

_____

_____

_____

_____

Emergency Contacts _____

_____

_____

Health Insurance Information

Company:_____ Policy#: _____

Group#:_____ ID#:_____

Family Physician Name:_____ Phone:_____

Address:_____ City:_____

If there are any custodial/legal rights of parents and/or guardians that we should be made aware of or

Photo Release: With my signature, I hereby grant permission to SS. John & Bernard Parish to publish my child's/ children's names, photos, or video images in connection with a display, feature story, or other publication as deemed appropriate by the Parish. This photo may be used in connection with parish bulletin boards, parish or youth ministry websites, publicity materials, and/or parish bulletins.

Permission is granted by : _____