Good through July '19

# PARENTAL CONSENT / STUDENT MEDICAL FORM

## June 1, 2018 through July 31, 2019

Student's Name:_____ D.O.B.:_____ Grade: _____

Student's Cell*: _____ Home Phone: _____

* Willing to receive texts? ☐ Yes ☐ No

Address: _____ City: _____

Student email: _____ School: _____

In case of an accident, I (we) authorize permission for the administration of first aid to my (our) student by those in charge as their judgment deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. I (we) understand that I (we) will be promptly notified in the event of any medical emergency except when the delay in such communication would endanger life. In the event that I (we) cannot be reached I (we) give permission to the physician selected by the adult staff to hospitalize, secure proper treatment for, and to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

I (we) will be liable and agree to pay all costs and expenses incurred in connection with such medical and dental service rendered to my (our) child pursuant to this authorization. **This release form covers the time span from June 1, 2018 through July 31, 2019.**

I understand that St. Mary of Vernon Youth Ministry may contact my child by phone/cell phone, texting, email, and/or Social Media.

I understand that photos and/or videos of my child may be taken periodically and that they may be posted in the bulletin, on the St. Mary of Vernon Parish website (with name omitted) [www.maryofvernon.org], and/or Parish social media pages. ☐ I consent ☐ I do not consent

**Parent(s)/Guardian** _____

Cell Phone No.1 _____ Cell Phone No. 2 _____

Parent(s) Email _____

**<u>Other Contact in case of emergency</u>:**

Name _____ Phone No. _____

**Authorized Physician** _____ Phone No. _____

**<u>Insurance Information:</u>**

Insurance Co. _____

Policy No. _____ Identification No. _____

**Please List any allergies and/or other medical conditions you think we should know about:**

**Signature of Parent/Guardian** _____ Date: _____