

# Emergency Medical Authorization Form

For the Mass Server's Outing to the Fort Wayne Tincaps game on August 10, 2017

Participant's Name \_\_\_\_\_ Parish \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

The undersigned do hereby release, forever discharge and agree to hold the Diocese of Toledo, the Missionaries of the Precious Blood, and the above named Parish and St. George Deanery Parishes harmless from and against any and all liabilities, claims, demands, lawsuits, and expenses arising from personal injury, sickness, death, or property damage of any nature whatsoever which may be incurred or suffered by the undersigned and or the participant (if participant is under 18, or 18 and older) while attending the Fort Wayne Tincaps game. Furthermore, the undersigned hereby assumes all risk of personal injury, sickness, death, damage and expense arising from the undersigned's or participant's (if participant is under 18 or 18 or older) participation in all activities, including recreation and work activities. The undersigned further hereby agrees to indemnify and hold the Diocese of Toledo, the Missionaries of the Precious Blood, the above named Parish and Deanery Parishes, and their respective members, directors, employees, and agents (collectively, the 'Indemnities') harmless from and against any and all claims, demands, actions, lawsuits, and liabilities, including attorney fees and expenses sustained by the Indemnities as the result of the negligent, willful, or intentional acts of the undersigned and /or participant (if participant is under 18 or 18 or older).

If participant is under 18 years of age: We (I), the parent(s) or legal guardian(s) of the participant, hereby grant permission for \_\_\_\_\_ to participate fully in parish, St. George Deanery, Missionaries of the Precious Blood, or Diocese of Toledo youth activities and events and all its undertakings. Furthermore, should it be necessary for the participant to return home due to medical reasons, disciplinary action or otherwise, I (we) assume all responsibility and transportation costs. Finally, I understand that the adults from our parish, society, deanery or diocese have full authority for enforcing the rules and making decisions for the good of the entire delegation. I will accept and support them.

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent(s)/ Legal Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

.....

## Information Release

I understand that by my child's participation in parish, Missionaries of the Precious Blood, St. George Deanery or Diocese of Toledo youth activities, his/her picture/image/video could be taken and used in press releases, brochures, videos, CD/DVDs, websites, etc for publicity use only. This authorization will remain in effect forever. I understand that I have the right to revoke this authorization at anytime by submitting a written request. This agreement does not obligate the use of your children's picture/image/video. If participant is under 18 years old, this must be signed by parent(s) or legal guardian.

\_\_\_\_\_ I grant permission. \_\_\_\_\_ I do not grant permission.

Participant's Signature \_\_\_\_\_

Parent(s)/ legal guardian signature \_\_\_\_\_ Date \_\_\_\_\_

.....

## Complete:

Yes, parent(s) of this child will be attending this event. NAMES: \_\_\_\_\_

No parents of this child will be attending this event.

## Emergency Medical Authorization Form

To enable parents and guardians to authorize the provision of emergency treatment for youth who become ill or injured while under the Parish Authority, when parents or guardians cannot be reached.

Student's Name \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

### Residential Parent or Guardian:

Mother's Name \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Father's Name \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Other Person to Contact if a parent cannot be reached.

Name \_\_\_\_\_ Relation to youth \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

**PART ONE: TO GRANT CONSENT (FILL OUT ONLY PART ONE OR PART TWO)**

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL TO BE CALLED.

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room Phone \_\_\_\_\_

In the event reasonable attempts to contact both parents and other contact person have been unsuccessful, I hereby give my consent to (1) the administration of any treatment deemed necessary by above named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to 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.

ALL KNOWN ALLERGIES: \_\_\_\_\_

Any other medical information \_\_\_\_\_

Signature of Parent(s)/ Legal Guardians \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Hospital Insurance  Yes  No

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

**PART TWO: REFUSAL OF CONSENT:**

I do NOT give my 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 the following action:

---

Signature of Parent(s)/ Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_