

**ST. ALOYSIUS GONZAGA
PARISH SCHOOL OF RELIGION (PSR)
CONSENT FORM
2011/2012**

STUDENT NAME _____
ADDRESS _____

TELEPHONE _____

PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under parish authority, when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT:

Mother's Name _____ Daytime Phone _____
Father's Name _____ Daytime Phone _____
Name of Relative or Neighbor _____
Who may be notified _____ Relationship _____
Address _____ Phone _____
Doctor to be called _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (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; and (2) the transfer of the child to any hospital reasonably accessible.

Preferred local hospital _____

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

Date: _____ Signature of parent/guardian _____

Address _____

PART II – REFUSAL TO 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 no action or to: _____

Date: _____ Signature of parent/guardian _____

Address _____
