EMERGENCY MEDICAL AUTHORIZATION AND RELEASE FOR TREATMENT (for minors)

This authorization enables the parent or guardian of a minor participant to authorize the provision of emergency treatment for the participant who becomes ill or injured while attending St Francis Xavier PSR and while in the care of or under the supervision of the Parish or its staff, employees, volunteers, agents and/or representatives when the parent or guardian cannot be reached. This must be signed in order for your child to participate in the event.

In the event reasonable attempts to contact me at _____ (home phone number) and at _____ (cell phone number) have been unsuccessful, I, the legal parent/guardian of _____, (name of child) hereby authorize any of the staff, employees, volunteers, agents and/or representatives of St. Francis Xavier Parish (each an "Authorized Party") to provide for, seek, and authorize medical treatment for him/her in the case of illness or accident from the closest and most appropriate licensed medical practitioner or hospital available.

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

Any and all information concerning the above named child's history including allergies, medications and physical impairments, has been reported in these registration forms. In the event of an emergency, I authorize any Authorized Party to share the completed registration information packet with persons related to the treatment of my minor child.

X_____ Date _____
Parent's signature (or participant if over 18)

Photo / Video Release

I (We) the parent(s) and/or guardian(s) of the minor child identified above hereby grant St. Francis Xavier Parish and/or its agents consent to record, photograph, audiotape, or videotape my minor child's name, image, likeness, spoken words, or projects, in any form, and to display, release, exhibit, publish, or distribute the same, or any part thereof, for any lawful Parish use or purpose including, without limitation, use in connection with the Parish's bulletin, website, social media sites, marketing materials, and any other uses as may not be contemplated herein, without further notice or compensation as follows:

□ I consent.
□ I do not consent.

I further understand that by entering into this informed consent and release, and by granting permission as stated herein, I hereby release the Parish, the Diocese of Cleveland, the Bishop of Cleveland, and their respective officers, directors, agents, employees and/or attorneys from and against any and all liability, loss, damage, costs, claims, and/or causes of action arising out of or related to the above items to which I have consented.

MEDICAL INFORMATION

Full Name: _____
Date of Birth: _____

Sex: ☐ Male Female ☐

Home Phone No.: _____
Cell Phone No.: _____
Diocese: Cleveland
Parish: _____

Emergency Contact #1:

Name of Emergency Contact: _____
Phone No. for Contact: _____
Relationship: ☐ Father Mother ☐
Other: _____

Emergency Contact #2:

Name of Emergency Contact: _____
Phone No. for Contact: _____
Relationship: ☐ Father Mother ☐
Other: _____

Medical Information:

Chronic Illnesses: _____
Allergies: _____
Current Medications: _____
Date of Last Tetanus Immunization: _____
Other: _____

Name of Doctor/Primary Care Physician: _____
Doctor/Primary Care Physician Phone No.: _____

Insurance Information:

Health insurance Co: _____
Member number: _____
Group number: _____
Group name: _____