Diocese of Venice

MEDICAL AUTHORIZATION FOR MINOR

NAME OF MINOR: _____ D.O.B._____Grade_____

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PARISH/~~SCHOOL~~: Epiphany Cathedral

HOME ADDRESS: _____

City _____ State _____ Zip_____

PARENTS/GUARDIANS: _____ / _____

PHONE #s: CELL-1: _____ CELL-2: _____

HOME: _____ WORK: _____

EMERGENCY CONTACT: _____

PHONE: _____

MEDICAL INFORMATION: Please list all pertinent medical information (for example, allergies, medications, physical impairments, or any other information necessary in an emergency situation). Explain fully:

In case of illness or injury of the above student(s), reasonable effort will be made to contact the parent(s)/legal guardian(s)/emergency contact. In case of a medical emergency, 911 will be called. In the event that the parents/ legal guardian(s)/emergency contact cannot be notified or are not available, I (we) authorize parish, school, or other pertinent diocesan officials to consent to any x-ray examination, anesthetic, medical or surgical treatment, and/or hospital care, as determined to be necessary and appropriate by a licensed physician in the State of Florida. This authorization is valid for a period of 1 year from the date of execution.

_____ _____

Signature of Parent or Legal Guardian Signature of Parent or Legal Guardian

Date_____