

St. Joseph Catholic Church _____ **CHURCH**
EMERGENCY MEDICAL AUTHORIZATION

Name of Participant: _____
Social Security Number: _____
Home Phone Number: _____
Street Address: _____
City, State, Zip: _____

PURPOSE: To enable participants to authorize emergency treatment should they become ill or injured while participating in church-sponsored event.

PART I OR PART II AND PART III MUST BE COMPLETED.

PART I – GRANT CONSENT In the event reasonable attempt to contact designated individuals as follows:

Emergency Contact: _____ **Relation:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

or

Emergency Contact: _____ **Relation:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by:

Preferred Physician: _____ **Office Phone:** _____

Physician #2: _____ **Office Phone:** _____

Or (2) in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and transfer of the participant to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained before surgery is performed.

I, the undersigned, understand that participation in activities inherently involve risk, including injury. As such, I hereby release, waive, discharge, and covenant not to sue from any loss, damage, or injury, including death, that may be sustained by myself, whether caused by negligence while participating in such activity where the activity is being conducted.

Facts concerning my medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Date

Signature of Participant

Address

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency treatment of myself. In the event of illness or injury requiring emergency treatment, I wish the church authorities to take no action or to:

Date

Signature of Participant

PART III

Please list below any information regarding ongoing medical conditions or medications (ex. Bee stings, diabetes, etc.)

Drug allergies, if any:
