



**St Joseph Catholic Church – Tiffin Ohio
2023-2024 Faith Formation (CCD) Program
Emergency Medical Form**



Today's Date: _____

The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under religious education authority when parents and guardians cannot be reached.

*****IMPORTANT – If you have more than one child and they have individual medical needs or concerns then each child would need their own individual form filled out.**

Name of First Student:(first middle last)_____ Grade:_____

Name of Second Student:(first middle last)_____ Grade:_____

Name of Third Student:(first middle last)_____ Grade:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Cell Phone #:_____

Allergies/Medical Concerns (list child's name):_____

Part 1 to Grant Consent:

I hereby give consent or the following medical care provider and local hospital to be called in the event reasonable attempts to contact me or my spouse has been unsuccessful. I hereby give my consent for 1. The administration of any treatment necessary by the named physician or dentist; and 2. The transfer of the child to any hospital reasonable 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 performance of such surgery.

Physician:_____ Phone:_____

Dentist:_____ Phone:_____

Specialist:_____ Phone:_____

Hospital:_____ Phone:_____

Signature:_____ Date:_____

Part 2: Refusal to Grant Consent

I do not give consent for emergency medical treatment of my child in the event of illness or injury requiring medical treatment.

I wish the administrator to take the following action:_____

Signature:_____ Date:_____

IMPORTANT * All information will be the same for all of my children the CCD program.**

Please circle: Yes No