

MEDICAL AUTHORIZATION FOR MINOR

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

PARISH/SCHOOL: _____

HOME ADDRESS: _____

PARENTS/GUARDIANS: _____ / _____

PHONE #s: WORK _____ / _____ HOME: _____ CELL _____

EMERGENCY CONTACT: _____ PHONE: _____

MEDICAL INFORMATION: Please list all information pertaining to allergies, diet needs, special medication, physical impairments, blood type, health conditions or any other information necessary in an emergency situation. Explain fully:

Child's Doctor: _____ Phone: _____

Address: _____

In case of illness or injury of the above student, reasonable effort will be made to contact the parent(s)/legal guardian(s)/emergency contact. In case of a medical emergency when these parties cannot be notified or are not available, I (we) authorize parish, school or other 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 physician licensed in the State in which treatment is sought. This authorization is valid for a period of 2 years from the date of execution. I (We) agree to assume financial responsibility for any medical treatment provided to the above minor and **a copy of the applicable health insurance card is attached.**

Signature of Parent or Legal Guardian

Signature of Parent or Legal Guardian

STATE OF FLORIDA
COUNTY OF _____

Before me personally appeared _____ and _____ who, being duly sworn, did represent under oath that he/she/they are the parent(s) and/or legal guardian(s) of the above named minor and he/she/they did sign this medical authorization before me this _____ day of _____, _____.

Notary Public
My Commission Expires:

Personally known to me _____ or
Produced _____ as identification.

**Please return this form to
the school or parish office.**