

ST. AUGUSTINE/ST. JOSEPH RELIGIOUS EDUCATION

CONSENT/REFUSAL TO CONSENT TREATMENT

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the named doctors in the family emergency records, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably 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 the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted must be list on the Student's Update form under ALLERGY / MEDICINE.

Date _____ Signature of Parent/Guardian _____

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the St. Augustine/St. Joseph Parish Center authorities to take the following action:

Date _____ Signature of Parent/Guardian _____

Please be advised that should you refuse consent to treatment, your child/children will not be permitted to participate in the program per the Archdiocese of Cincinnati.