

**ST. ALOYSIUS GONZAGA  
PARISH SCHOOL OF RELIGION (PSR)  
CONSENT FORM  
2010/2011**

STUDENT NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE \_\_\_\_\_

**PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under parish authority, when parents or guardians cannot be reached.**

**PART I OR II MUST BE COMPLETED**

**PART I – TO GRANT CONSENT:**

Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
Name of Relative or Neighbor \_\_\_\_\_  
Who may be notified \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Doctor to be called \_\_\_\_\_ Phone \_\_\_\_\_

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 above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician; and (2) the transfer of the child to any hospital reasonably accessible.

Preferred local hospital \_\_\_\_\_

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, 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: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

**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 parish authorities to take no action or to: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_