(Office Use) _____

Emergency Medical Authorization Form
Saint Ambrose Religious Education Program

Child's Full Name _____ Gender M / F Grade _____ Age _____

Parent/Guardian Names_____

Birth date _____/_____/_____ Her Cell_____ His Cell _____

Address_____

Child's Doctor_____ Phone_____

Child's Dentist_____ Phone_____

Hospital of Choice_____ Phone_____

Insurance Provider_____ Phone_____

Please list any medical issues/concerns: _____

_____

List any allergies or sensitivities your child might have to any food, drink, or materials that might be used during class: _____

Does your child have any medical allergies? (If yes, please list)_____

_____

Are there any activities in which your child may not participate? _____

Please list names and phone numbers of person(s) to call in case of an emergency:

Name_____Relationship to child_____

Phone_____Cell_____

Name_____Relationship to child_____

Phone_____Cell_____

Part 1-Grant Consent

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I hereby grant my consent for (1) the administration of any treatment deemed necessary by the above medical professionals, or in the event the designated preferred practitioner or facility is not available, by another licensed medical practitioner; and (2) the transfer of the child to the above named facility or any reasonably accessible hospital.
The authorization does not cover any major surgery unless the medical opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery and concurrence is obtained before the surgery is performed.

Parent/Guardian Signature:_____ Date: _____

Part II-Refusal to Consent

I **do not** give my consent for emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the school authorities to take no action or to:_____

Parent/Guardian Signature:_____ Date: _____

PHOTO RELEASE AND AUTHORIZATION

I (we) the parent(s) and/or guardian(s) of my minor child _____do hereby consent and authorize the release, publication, dissemination, distribution, use and/or reproduction of any and all photographs taken of my (our) daughter/son during her/his participation at Saint Ambrose programs by an employee, agent or representative of Saint Ambrose or independent contractor.
This RELEASE AND AUTHORIZATION acknowledges that all photographic negatives, positives, and prints shall constitute the property of Saint Ambrose and may be used by Saint Ambrose for any purpose determined at its discretion without further notice or any compensation to me or my daughter/son.
PARENT(S)/GUARDIAN SIGNATURE _____ DATE _____

Please return to: Saint Ambrose PSR Office 929 Pearl Rd. Brunswick, Ohio 44212 330-460-7302