Diocese of Venice
1000 Pinebrook Road, Venice, FL 34285
(941) 484-9543

MEDICAL AUTHORIZATION FOR MINOR

NAME OF MINOR: ________________________________ D.O.B. ________________

PARISH: ____

HOME ADDRESS: ____

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PARENTS/GUARDIANS: ____

PHONE #s: WORK ___________________________ HOME: ______________________

CELL: ___________________________

EMERGENCY CONTACT: ____

PHONE: ____

MEDICAL INFORMATION: Please list all pertinent information concerning any special health conditions your child may have, or other information you would like us to have in an emergency (blood type, for instance). Severe allergies and all medications your child routinely takes should be listed here.

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Child's Doctor: ___________________________ Phone: ____________________________

Address: ____

In case of illness or injury of the above student, all reasonable efforts 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 the parish 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 licensed physician in the State of Florida. This authorization is valid for a period of 1 year from the date of execution.

___________________________________	___________________________________
Signature of Parent of Legal Guardian	Signature of Parent or Legal Guardian