# **St. Joan of Arc Faith Formation**

# **Emergency Medical Authorization 2024-25**

*One form per family.*

Click on each box to fill – save – and return by email to [officeoffaithformation@stjoanofarc.org](mailto:officeoffaithformation@stjoanofarc.org)

# Child/ren’s Full Names:

Purpose - to enable parents and guardians to organize the provision of emergency treatment for Children who become ill or injured while under Faith Formation authority, when parents or guardians cannot be reached.

Please indicate with a star who should be called first:

Mother: Primary Phone:

Father: Primary Phone:

**Emergency Contact if unable to reach parent:**

Name/Relationship:

Primary Phone:

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Family Physician Name:

Phone Number:

Preferred Hospital:

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**TO GRANT CONSENT**

If the above individuals cannot be reached: I hereby give consent for the administration of any treatment deemed necessary   
by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician; and the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

The attached Confidential Health form lists facts concerning each child’s medical information, including allergies, medications, and any important medical history to which a physician should be alerted.

Parent Signature/Date:

**~ OR ~**

**TO REFUSE CONSENT**

I DO NOT give consent for the emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the authorities to take no action or to:

Parent Signature/Date: