



# LIFE TEEN

LITTLE FLOWER CATHOLIC PARISH

### Registration & Emergency Medical Authorization

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ School & Grade: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Child's Cell Phone: \_\_\_\_\_ Child's Email: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Cell Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's cell Phone: \_\_\_\_\_

Parent E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Can we send your child: Text Notifications? Yes\_\_ No\_\_ Would you like to receive: Text Notifications? Yes\_\_ No\_\_  
Email Notifications? Yes\_\_ No\_\_ Email Notifications? Yes\_\_ No\_\_

**There may be times when pictures are taken of your child for promotional purposes. Please indicate your preference and sign.** Permission given \_\_\_ Permission **Not** given \_\_\_ Signature \_\_\_\_\_

### Emergency Contact if parents are not available

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Facts concerning your child's medical history including allergies, medicines being taken or physical limitations that the Life Teen Core Members should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Part 1: To Grant Consent

I hereby give consent for the following medical care providers and local hospitals to be called:

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_ 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 my child to any hospital reasonably accessible. 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.

**Signature of Parent or Guardian:** \_\_\_\_\_ **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 injury requiring medical treatment, I wish the Life Teen Core Members to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_