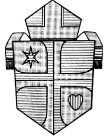

Official Legal form for the Diocese of Salina

FORM C

Date ____________________

MEDICAL PERMISSION FORM

This form is to be used for any parish, Catholic school, or diocesan field trips.

Diocese Salina Parish ____________________ School ____________________

Participant's Name ____

Destination ____

TO WHOM IT MAY CONCERN:
I/We understand that first aid will be available on the above mentioned trip. I/We further understand that should an accident, injury, or illness occur, medical and/or hospital care will be obtained. I/We realize the sponsors will make a reasonable effort to notify me/us in case of accident, injury, or illness; however, should they be unable to contact me/us, they have my/our permission to pursue a course of medical action which is in the best interest of the child.

I/We grant permission for the administration of first aid care to (child) ____________________
by the people in charge of the ____________________ and those transporting my child to and from the ____________________ as their judgment deems advisable and to make the necessary referrals to qualified physicians or health care providers for treatment of illness or accidents. I/We understand that a reasonable effort will be made to promptly notify me in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, in the event I/we cannot be reached, I/we hereby give permission to the physician or health care provider selected by the adult staff to hospitalize, secure proper treatment for, and order whatever injection, anesthesia, or surgery said physician or health care provider deems necessary for the child.

A doctor, clinic, hospital or health care provider may proceed with any medical or surgical treatment that such sponsor may authorize.

I further understand that I will be responsible for all medical, surgical, and transportation costs which may be incurred.

INSURANCE INFORMATION:

Insurance Company ** ____________________ Policy No. ____________________

Policy Holder ____________________ Date of Birth ____________ Occupation ____________

Employer ____________________ Address ____________________

Employer's phone # ____________________

** If Blue Cross/Blue Shield Insurance please state if it is Blue Choice, Blue Select, etc.

(Father)	(Mother)
(Father)	(Mother)
Home Phone ____________	Home Phone ____________
Work Phone ____________	Work Phone ____________

If unable to contact either parent above, I grant permission to contact:

(Friend or Relative)	(Home or Work Telephone #)
(Family Physician)	(Physician's Telephone #)
Parent/Legal Guardian Signature	Parent/Legal Guardian Signature