Emergency Medical Contact, Treatment, and Release of Information Form

Required for PSR

Participant (children's) Names:
_____

I. Emergency Medical Contact And Treatment

Parent or Guardian _____

Medical Insurance _____ Policy Number _____

Member's Name _____ Phone ( ) _____

Family Doctor_____ Phone ( ) _____

I. Emergency Medical Treatment

In the event of an emergency, the undersigned hereby give(s) permission to transport the Participant to a hospital for emergency medical or surgical treatment. The undersigned wish(es) to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if the undersigned cannot be reached at the above numbers, contact:

Name & relationship: _____ Phone: ( )_____

II. Consent For Release Of Personally Identifiable Information (Leave blank if Consent not granted.)

The undersigned hereby consent to the release of photographs and name of these Participants to be used by the Diocese of Columbus and _____St. Christopher Parish, Grandview_____ (PARISH NAME) for future promotional programs of the Diocese and Parish. If you have any questions or concerns, please contact ____Linda Wolfe, DRE_____(PARISH POINT OF CONTACT) at __(614) 486-0457, ext. 3 _ (PHONE NUMBER).

Parent or Guardan Signature _____

Date _____

Linda Wolfe
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St. Christopher
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