AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

AND RELEASE OF ALL CLAIMS

For Youth & Adults To be completed by parent/guardian of minor, or by adult.

Employer Name	Name First	Birtl	ndate _	1	1	Sex _	Age	
Employer Name	LEST FROM	# IR.						
Employer Name	Father/Guardian		Pho	ne				
Employer Name	Employer Name	Emplo	yer Pho	ne		·		
Home Address If not available is an emergency, please noilly: Name Phone Relationship I give my consent for the administration of any emergency treatment deemed necessary by a registered nurse, a licensed physician or dentist; and the transfer of the minor to any hospital reasonably accessible when medically necessary. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians concurring in the necessify for such surgery are obtained prior to the performance of such surgery. Family Physician Phone Dentist/Orthodontist Phone Do you carry medical/hospital insurance? Yes No If yes, please indicate: Company Policy/Group # Food/Drug Allergies Specific Needs in Regards to Food Operations (what/when) Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? Yes No If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by (event), I hereby release the Bishop of the Diocese of Baker, the Diocese, (parish) to participate in (event), I hereby release the Diocese of Baker and other above described parties, for all personal injuries or to other claims for refer known or unknown which said child or ward has or may incur by participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. I, the undersigned, have read this release and understand all its terms. I execute it voluntarity and with full knowledge of its significance. In witness whereof, I have executed this release on the Day of , 20	Mother/Guardian		Pho	ne				
Phone	Employer Name	Emplo	yer Pho	ne				
Phone	-							
I give my consent for the administration of any emergency treatment deemed necessary by a registered nurse, a licensed physician or dentist; and the transfer of the minor to any hospital reasonably accessible when medically necessary. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Family Physician Phone Dentist/Orthodontist Phone Do you carry medical/hospital insurance? Yes No If yes, please indicate: Company Policy/Group # Food/Drug Allergies Specific Needs in Regards to Food Operations (what/when) Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? Yes No If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by (parish) to participate in (parish), its agents and employees from all action, causes of actions, or damages claims, demands which I, my heirs, executors, administrators, or assigns may have against the Diocese of Baker, for all personal injuries or to other claims for refer known or unknown which said child or ward has or may incur by participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. I, the undersigned, have read this release and understand all its terms. I execute it voluntarity and with full knowledge of its significance. In witness whereof, I have executed this release on the Day of , 20						······································		
I give my consent for the administration of any emergency treatment deemed necessary by a registered nurse, a licensed physician or dentist; and the transfer of the minor to any hospital reasonably accessible when medically necessary. This suthroization does not cover major surgery unless the medical opinion of two other licensed physicians concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Familty Physician Phone Dentist/Orthodontist Phone Dentist/Orthodontist Phone Do you carry medical/hospital insurance? Yes No If yes, please indicate: Company Policy/Group # Food/Drug Allergies Specific Needs in Regards to Food Operations (what/when) Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? Yes No If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by (parish) to participate in (event), I hereby release the Bishop of the Diocese of Baker, the Diocese, (parish), its agents and employees from all action, causes of actions, or damages claims, demands which I, my heirs, executions, administrators, or assigns may have against the Diocese of Baker and other above described parties, for all personal injuries or to other claims for relief known or unknown which said child or ward has or may incur by participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. I, the undersigned, have read this release and understand all its terms. I execute it wountarity and with full knowledge of its significance. In witness whereof, I have executed this release on the Day of 20		Phone				Relationship		
physician or dentist; and the transfer of the minor to any hospital reasonably accessible when medically necessary. This authorization does not cover major surgery unless the medical opinion of two other icensed physicians concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Family Physician Phone Dentilst/Orthodontist Phone Do you carry medical/hospital insurance? Yes No If yes, please indicate: Company Policy/Group # Food/Drug Allergies Specific Needs in Regards to Food Operations (what/when) Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? Yes No No THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS, RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by (parish), to participate in (event), I hereby release the Bishop of the Diocese of Baker, the Diocese, (parish), its agents and employees from all action, causes of actions, or damages claims, demands which I, my heirs, executors, administrators, or assigns may have against blooces or Baker and other above described parties, for all personal injuries or to other claims for reflet known or unknown which said child or ward has or may incur by participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. I, the undersigned, have read this release and understand all its terms. I execute it voluntarity and with full knowledge of its significance. In witness whereof, I have executed this release on the	(Valle)				······			
Dentist/Orthodontist	authorization does not cover major surgery unle necessity for such surgery are obtained prior to	ss the medical opinion of the performance of such	of two oth surgery	her li	censed	physicians	•	
Do you carry medical/hospital insurance? Yes No If yes, please indicate: Company Policy/Group # Food/Drug Allergies Specific Needs in Regards to Food Operations (what/when) Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? Yes No If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by (parish) to participate in (event), I hereby release the Bishop of the Diocese of Baker, the Diocese, (parish), its agents and employees from all action, causes of actions, or damages claims, demands which I, my heirs, executors, administrators, or assigns may have against the Diocese of Baker and other above described parties, for all personal injuries or to other claims for relief known or unknown which said child or ward has or may incur by participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. I, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance. In witness whereof, I have executed this release on the Day of, 20					_ ` ` ` `	-		
Food/Drug Allergies Specific Needs in Regards to Food Operations (what/when) Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by						*********		
Specific Needs in Regards to Food Operations (what/when) Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? Yes No	Do you carry medical/hospital insurance?		-		e indica	ate:		
Operations (what/when) Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? Yes No If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by	Company Policy/Group #							
Disability/Chronic Illness Is youth or adult taking medication prescribed by a physician now? Yes No If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by (parish) to participate in (event), I hereby release the Bishop of the Diocese of Baker, the Diocese, (parish), its agents and employees from all action, causes of actions, or damages claims, demands which I, my heirs, executors, administrators, or assigns may have against the Diocese of Baker and other above described parties, for all personal injuries or to other claims for relief known or unknown which said child or ward has or may incur by participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. I, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance. In witness whereof, I have executed this release on the Day of , 20	Food/Drug Allergies					<u> </u>		
Is youth or adult taking medication prescribed by a physician now? If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by	Specific Needs in Regards to Food					·.·.		
Is youth or adult taking medication prescribed by a physician now? If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by	Operations (what/when)							
If so, please list all medications prescribed, the size of dose, and when it is to be taken. ALL MEDICATION MUST BE GIVEN TO THE TRIP LEADER AND WILL BE DISPENSED ACCORDING TO DIRECTIONS. RELEASE OF ALL CLAIMS In consideration of the permission granted to the above named by	Disability/Chronic Illness				٠			
In consideration of the permission granted to the above named by	If so, please list all medications prescribed, the size of	dose, and when it is to be to					GIVEN	
participate in	!	RELEASE OF ALL CLAI	MS					
the Diocese,	-					bo Dishon of #		
claims, demands which I, my heirs, executors, administrators, or assigns may have against the Diocese of Baker and other above described parties, for all personal injuries or to other claims for relief known or unknown which said child or ward has or may incur by participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. 1, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance. In witness whereof, I have executed this release on the	• • •	*	• • •	-		-		
participating in the above described activity/event and which would normally occur as an assumed risk of participating in said activity or activities. 1, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance. In witness whereof, I have executed this release on the								
or activities. 1, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance. In witness whereof, I have executed this release on the Day of, 20	• • •						•	
	or activities. 1, the undersigned, have read this release						-	
	In witness whereof, I have executed this release on th	eDay of						
ADULT/PARENT/GUARDIAN'S SIGNATURE DATE	ADULT/PARENT/GUARDIAN'S SIGNATURE					DATE		