



*DIOCESE OF VENICE IN FLORIDA*

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**MEDICAL AUTHORIZATION FOR MINOR**

NAME OF MINOR: \_\_\_\_\_ D.O.B. \_\_\_\_\_

PARISH/SCHOOL: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

PARENTS/GUARDIANS: \_\_\_\_\_ / \_\_\_\_\_

PHONE #s: CELL: \_\_\_\_\_ HOME: \_\_\_\_\_

WORK: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

PHONE: \_\_\_\_\_

MEDICAL INFORMATION: Please list all pertinent medical information (for example, allergies, medications, physical impairments, or any other information necessary in an emergency situation). Explain fully:

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In case of illness or injury of the above student, reasonable effort will be made to contact the parent(s)/legal guardian(s)/emergency contact. In case of a medical emergency, 911 will be called. In the event that the parents/ legal guardian(s)/emergency contact cannot be notified or are not available, I (we) authorize parish, school, or other pertinent diocesan officials to consent to any x-ray examination, anesthetic, medical or surgical treatment, and/or hospital care, as determined to be necessary and appropriate by a licensed physician in the State of Florida. This authorization is valid for a period of 1 year from the date of execution.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Date: