

**St. Frances X. Cabrini Church
Medical Authorization for Minor**

Name of Minor: _____ Phone _____

Home Address: _____ D.O.B. _____

Parents/Guardians: _____

Phone #s: Work _____ Home _____ Cell _____

Emergency Contact: _____ Phone: _____

Medical Information: Please list all information pertaining to allergies, diet needs, special medications, physical impairments, blood type, health conditions or any other information necessary in an emergency situation. Explain Fully:

_____ Plea
se attach a physician's dated order for any medications to be administered on site.

Minor's Primary Care Physician: _____ Phone: _____

Address: _____

In case of illness or injury of the above minor, reasonable effort will be made to contact parent(s)/legal guardian(s) emergency contact. In case of medical emergency when these parties cannot be reached/are not available, I (we) authorize the parish and other 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 physician licensed in the State in which treatment is sought. This authorization is valid for a period of one year from the date of execution. I(we) agree to assume financial responsibility for any medical treatment provided to the above minor and a copy of any applicable health insurance card is attached.

Please wait to sign before a notary public:

Signature of Parent/Legal Guardian

Signature of Parent/Legal Guardian

State of Florida County of _____

Before me personally appeared _____ and _____

Who, being duly sworn, did represent under oath that he/she/they are the parent(s) and/or legal guardian(s) of the above named minor and he/she/they did sign this Medical Authorization and Parent/Guardian Consent, Release of Liability and Indemnification. this day of _____, _____.

Personally known to me _____ or _____

Produced _____ and _____ as identification.

Notary Public

My Commission Expires: