

**St. Therese Catholic Community**

1260 NE 132<sup>nd</sup> Ave., Portland, OR 97230 ..... Tel 503-256-5850

**SACRAMENTAL CATECHESIS & FAMILY RELIGIOUS EDUCATION  
EMERGENCY INFORMATION AND CONSENT FORM**

**PURPOSE (READ THIS STATEMENT)**

Information on this form will first be used to contact parents, if your child requires any medical care. If your child, however, should happen to require serious emergency medical attention and you are not available to give consent to medical authorities, care may be unnecessarily delayed. To protect your child, please consider completing this form. In the event of a medical emergency during our regularly scheduled programs, this form will accompany your child to the hospital/clinic so that a decision to render proper and necessary medical treatment can be made by the medical facility and responsible medical personnel.

FAMILY NAME \_\_\_\_\_ PARENT(S) FIRST NAMES \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ EMERGENCY PHONE \_\_\_\_\_

FATHER'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

MOTHER'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT (relative or friend) \_\_\_\_\_ PHONE \_\_\_\_\_

<u>Child's Name</u>	<u>Birth Date</u>	<u>Chronic Illness</u>	<u>Allergies</u>	<u>Medications</u>	<u>Last Tetanus</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FAMILY DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

HOSPITAL OF PREFERENCE \_\_\_\_\_

PRIMARY MEDICAL INSURANCE CARRIER \_\_\_\_\_

GROUP NO. \_\_\_\_\_ MEMBER NO. \_\_\_\_\_

**CHECK ONE AND SIGN BELOW**

**CONSENT** - I / We the undersigned, give my/our permission for our child to be medically evaluated, diagnosed, and treated in accordance with standard medical practice by licensed medical personnel. I/We will not hold St. Therese Parish, the Archdiocese of Portland in Oregon, their agents, chaperons, or their representatives responsible in the event of illness or injury or for the consequences that may arise as a result of this treatment. I/We agree to accept any and all financial responsibility as a result of any such treatment.

**NON-CONSENT** - I / We the undersigned do not wish to give our consent for emergency medical treatment. (Complete top portion only and sign form.)

**SIGNED: PARENT(S)/GUARDIAN(S)** \_\_\_\_\_ **DATE** \_\_\_\_\_

\_\_\_\_\_ **DATE** \_\_\_\_\_