2023-2024 ADULT ANNUAL EMERGENCY MEDICAL CARE FORM

Note: Participants must complete, sign, and submit this form prior to the commencement of each Parish Youth Ministry Program year. **Participants are responsible for updating the information on this form should changes occur during the Parish Youth Ministry Program year.**

CONSENT TO EMERGENCY MEDICAL CARE

Participant Name:_____   Parish: _____

In the event of an emergency, I request that the parish make reasonable attempts to contact _____ (name) at _____ (phone number) or _____ (name) at _____ (phone number)

I understand that in an emergency, exigent circumstances may prevent the parish from contacting the above listed emergency contacts immediately, or the parish may be unable to reach them. I therefore consent to the parish taking action which it deems necessary to secure emergency medical care/treatment.

I understand that decisions concerning the type of emergency medical care or treatment administered are normally made by health care providers and not by the parish and that exigent circumstances may require the administration of emergency medical care or treatment without my prior consent. However, I have indicated below any treatment preferences I have which the parish may disclose to a health care provider. (participants may check the following):

_____   Dr. _____ is my preferred physician and Dr. _____ is my preferred dentist.

_____   _____ is my preferred hospital.

_____   Other: _____

The parish may also disclose the following checked information to a health care provider:

_____   Insurance Information: Insurance Company Name: _____
                                                       Policy/Group/Claim No.: _____

_____   The following information regarding allergies I have, medication I am taking,
              and other medical facts: _____
_____

I understand that in the event of an emergency, the parish will make reasonable efforts to notify a health care provider of the above-checked information, but I acknowledge that I am responsible for communicating such information to the appropriate medical personnel.

_____ _____   _____
 Date   Participant Signature   Email

02/2018