Authorization of Consent to Treatment of a Minor for:
YOUTH RETREAT

Permission for _____, _____ to receive medical treatment during
(child's name) (date of birth)
the Youth Retreat has been agreed upon within the separate RELEASE AND INDEMNIFICATION AGREEMENT for Youth Retreat. I understand that the Apostolate for Family Consecration will attempt to reach me for any incident requiring medical treatment. If for any reason I cannot be reached after a reasonable number of attempts, the Apostolate for Family Consecration may give an informed consent for treatment taking into account the following facts concerning the child's **medical history**. This includes **allergies, physical impairments, and medications being taken** which a physician should be made aware of:

_____

_____

_____

_____

Our family physician is Dr. _____Phone: _____

Our family Dentist is Dr. _____ Phone: _____

Our hospital of choice is: _____

Our health insurance plan is: _____
(if any) (I.D. number)
This authorization expires at noon on _____, 20_____
(month) (day) (year)

The following procedures should not be performed without my consent unless the concurring medial opinion of two physicians is that such procedures are necessary to relieve the suffering or preserve the life or limb of such child and I cannot be reached after reasonable attempts:

a) Major surgery
b) _____
(other if any)

_____
Signature of Parent Date

_____
Street Address

_____
City State Zip code

_____
Home Phone Cell Phone

331-123

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