

**AUTHORIZATION FOR MEDICAL TREATMENT**

I/We \_\_\_\_\_, of \_\_\_\_\_  
(Legal guardians) (Address)

Ohio, am/are the mother/father of \_\_\_\_\_, a minor who is in the care and custody of St. Mary Parish PSR Program and St. Mary Parish, Hudson.

I/We hereby give my/our consent for St. Mary in the event that all reasonable attempts to contact me/us at \_\_\_\_\_ or \_\_\_\_\_ have been  
(Home phone) (Work/cell phone)  
unsuccessful, to seek medical attention and treatment deemed necessary by:

**Physician**

Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**And/or**

Dentist

Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Transfer of the minor to \_\_\_\_\_ or a hospital reasonably accessible.  
(Hospital)

**Insurance Information**

Is the participant covered by hospitalization insurance? y/n \_\_\_\_\_ Company: \_\_\_\_\_

Group/policy # \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to patient \_\_\_\_\_

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concur in the necessity for such surgery and are obtained before surgery is performed.

Can participant be given medicine for a headache? \_\_\_\_\_

Date: \_\_\_\_\_  
(Mother/Father Signature)

Date: \_\_\_\_\_  
(Participant's Signature if 18 years or older)

**MEDICAL HISTORY**

List any allergies to any medications:

\_\_\_\_\_  
\_\_\_\_\_

Any recent major illnesses: \_\_\_\_\_

Presently on any medication? \_\_\_\_\_ If YES, please list them and times needed:

\_\_\_\_\_  
\_\_\_\_\_

Any physical limitations or medical problems the staff should be aware of? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_