

## **CONSENT FOR EMERGENCY MEDICAL TREATMENT**

As the parent/guardian of \_\_\_\_\_  
(Student Name)

I hereby give consent to St. John the Baptist Parish Catechetical Ministry to obtain all emergency medical or dental care prescribed by a duty licensed physician (M.D.), osteopath (D.O.) or dentist (D.D.S.) for my child. This care may be given under whenever conditions are necessary to preserve the life, limb or wellbeing of the child named above. My child has the following medication allergies:

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In case of emergency of minor injury, I authorize that first aid be administered  
By person qualified to render such services.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_