St. Sebastian Parish
476 MULL AVENUE • AKRON, OHIO 44320-1299 • 330.836.2233 • www.stsebastian.org

AUTHORIZATION FOR MEDICAL TREATMENT
Part I or II must be completed

PART I

I/We _____, of _____ Ohio, am/are the mother/father of

_____, a minor who is in the care and custody of St. Sebastian Parish School of Religion

(PSR). I/We hereby give my/our consent for St. Sebastian Parish. In the event reasonable attempts to contact me, _____, at _____ or _____ at _____
(Parent/Guardian) (Phone number) (other parent/guardian) (Phone number)

have been unsuccessful, I/We, as the parents or legal guardian of _____ do hereby give
(Student's Name)

my/our consent for St. Sebastian Parish staff, or an adult representative of the St. Sebastian Parish School of

Religion program to seek medical attention and treatment deemed necessary by: Dr. _____
(preferred physician)

at _____ and/or Dr. _____ at _____, or in the event the designated
(Phone Number) (preferred dentist) (Phone Number)

preferred practitioner is not available, by another license physician or dentist; and give permission to transfer my

child to _____ or any hospital reasonably accessible. This authorization does not cover major
(preferred hospital)

surgery, unless the medical opinion of two other licensed physicians or dentists concur on the necessity for such

surgery is obtained prior to the performance of such surgery.

Please list any medical conditions, allergies, medications, special physical or dietary needs, etc., that we should be aware of:_____
_____
_____

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

X_____
Parent/Guardian Signature Date

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PART II REFUSAL TO CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the St. Sebastian Parish School of Religion or adult representative to take no action or to:_____
_____
_____

X_____
Parent/Guardian Signature Date