Holy Trinity School
Authorization to Give Consent For Treatment of a Minor

Note: This authorization form allows the designated person(s) to give consent for the medical care of a specific child.

I (We), the undersigned, parent(s) or guardian(s) of _______________, a minor
Child's full name

Authorize______________________ and ______________________________
Coach Coach

As agent(s) for the undersigned, to give consent for emergency medical care prescribed by a duly licensed physician or dentist. This consent may be given for care given whenever conditions are necessary to preserve the life, limb or well being of my dependent except for limitations indicated:
Limitations: (NA if none)

____

____
(continue on attachment if necessary)

This authorization is effective until__________
Date

Signed:____________________________Date_________

____
Print Name (Parent/Guardian)

____
Address

____
City, State Zip

Contact Information:

Home:_________________ Work:_________________Cell:_______________
Phone Phone

Home:_________________ Work:_________________Cell:_______________
Phone Phone

Physicians Information:

Child's Physician: ______________________________________
Phone: ______________________________________
Address: ______________________________________
Hospital Preference: ______________________________________
Relevant Medical History*:

____

____

- Chronic conditions, allergies, current medications, previous broken bones, dislocations, sprains, concussions, etc.

Person to Contact in Emergency if parent or guardian is unavailable or cannot be reached:
Name:______________________________Phone:_____________________

I/we have read, understand, and will abide by the parent/guest guidelines as outlined in the Athletic Handbook (page # 7) found on the Holy Trinity Web-site (www.htschool.org).

Signed: ___________________________________ Date:___________
Parent or Guardian