Name: _____ **Birth date:** _____

St Julie Billiart Youth Ministry Program
Authorization for Medical Treatment

In the event that the undersigned, or my authorized physician cannot be reached, and in the judgment of the Youth Minister or other Adult Supervisors of St. Julie Billiart Youth Ministry, there is necessity for immediate examination and / or treatment of our child, I hereby authorize any of the aforesaid personnel to obtain for our child such medical services deemed necessary.

_____ _____

Parent / Guardian Signature | Parent / Guardian Signature (if applicable)

_____ _____

Home Address | Home Phone Number

_____ _____

City, State, Zip Code | Parent / Guardian Work Phone Number

Insurance Information

_____ _____

Family Physician | Hospitalization Plan

_____ _____

Phone Number | Policy Number / Group Number

_____

Medical Conditions, Allergies or Restrictions **(attach additional paper if more details are necessary)**

Emergency Name / Number - 1. _____

2. _____

Special Dietary needs _____

Photo Permission: *On occasion, photos taken from various events are used for publicity in our parish bulletin, websites and TNT Facebook page.* ***If you do not want*** *your child photographed, please sign below. Lack of signature will be implied permission to photograph. If you have any questions, please call the office. 708 429 7377.* _____ ***(parent / guardian signature)***