|  |  |
| --- | --- |
| **FAMILY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| In case of emergency, I grant consent to: | **St. Michael Faith Formation** |
| to authorize medical care for my minor child/children: | |
| Child #1 | |
| Child #2 | |
| Child #3 | |
| Child #4 | |
| **Our family doctor is:** |  |
| **The hospital we use is:** |  |
|  |  |
| **Medical Conditions:** | **PLEASE LIST** |
| Child #1 |  |
| Child #2 |  |
| Child #3 |  |
| Child #4 |  |
|  |  |
| **Alternative Contact** |  |
| **Name** |  |
| **Phone** |  |
| **Signature** |  |
| **Printed Name** |  |
| **Phone** |  |
| **Date** |  |

**Due to Faith Formation Office by: April 22, 2024**