
	<p><b>LASALLIAN YOUTH</b>  <b>Mission to Mexico</b>          March 13<sup>th</sup>–March 24<sup>th</sup>, 2008</p> <p><i>Faces of Christ</i>  <i>Faces of Mission</i></p>	 <b>Hermosillo, Senora</b> <b>Mexico</b>
--	---	---

# Consent to Treatment

Individual's Name (herein "Lasallian Youth")
--

School (herein "Organization")
<b>Archbishop O'Hara High School</b>

If Lasallian Youth Member is under 18 years of age.	Name (herein "Parent or Guardian")
	Name (herein "Parent or Guardian")

Teacher or Staff Member (herein "Agent")
<b>Br. Charles Gregor</b>

Teacher or Staff Member (herein "Agent")
<b>Mr. Peter Jones</b>

I, \_\_\_\_\_ as (circle one) the **parent** / the **guardian** / the **Lasallian Youth**, do hereby authorize the Agent, acting as the Lasallian Youth's agent, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care or service, which is deemed advisable and is rendered under the general or specific supervision of any licensed physician and surgeon, or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being rendered, but is given to provide authority and power on the part of the Agent to give specific consent to any or all such diagnosis, treatment, or hospital care which the above mentioned physician, in the exercise of his best judgment, may deem advisable.

I hereby authorize any hospital which has provided treatment to the Lasallian Youth member to surrender physical custody of the Lasallian Youth member to the Agent upon completion of treatment.

These authorizations shall remain in effect through the above periods unless sooner revoked in writing and delivered to the Agent.

Signature of Lasallian Youth	Date
Social Security Number	
Insurance Company	Policy Number
Claim Office Address	
City, State, Zip	
Doctor's Name	Phone Number
Date of last Tetanus	
Please list any allergies, medications, illnesses or disabilities of Lasallian Youth	

Signature of "Parent or Guardian"	Date	
Address		
City, State, Zip		
Home Phone	Work Phone	
Signature of "Parent or Guardian"		
Address (If same as above write "Same")		
City, State, Zip		
Home Phone	Work Phone	
In case of medical emergency, if parents cannot be reached, notify:		
Name	Home Phone	Work Phone

If Lasallian Youth is under 18 years of age.