

Parental Consent/Medical Treatment Form

Name of Church: _____ Youth Leader: _____

Event: _____ Location: _____

I, the undersigned parent or guardian of _____, a minor, do hereby authorize adult workers with the youth of the above named church to consent to any examination, x ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Further, as parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.

Insurance Company or Group: _____ Policy number: _____

(Please print the following information)

Name of Participant: _____ Name of Guardian: _____

Address: _____

City: _____ State _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Medications: Name _____ Dosage: _____

Allergies: _____

Signature of Parent or Guardian

My signature confirms that I hereby give witness to the proper completion of this form by the minor's parent or guardian