

PARENTAL CONSENT/MEDICAL TREATMENT FORM

This form must be completed in full and notarized.

Important note to Parent(s)/Guardian: Make trip leader aware of any special medical condition, treatment, or prescribed drugs to be taken when returning this form.

Name of organization: Christ United Methodist Church

I, the undersigned parent or guardian of _____, a minor, do hereby authorize any adult youth leader on said trip 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 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, surgeon, hospital, or other medical center without the necessity of first notifying me and that neither physician, surgeon, hospital, or other medical center involved assumes any financial responsibility for acting under the authority granted by this consent authorization.

PLEASE PRINT THE FOLLOWING INFORMATION:

Insurance Company or Group: _____

Policy Number: _____

Name of Participant: _____ Date of Birth: ___/___/___

Parent or Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Notify in emergency: _____ Relationship: _____

Address: _____ Phone: _____

Family Physician: _____ Phone: _____

Medicines being takes (include dosage/frequency): _____

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.

Date: _____

Signature of Notary: _____ Commission Expires: _____