

Authorization to Consent to  
Treatment of Minor

\_\_\_\_\_ (name of parent or guardian), am the parent or legal guardian of  
\_\_\_\_\_ a minor, (hereinafter "my child"), who was born on \_\_\_\_\_ (day/month/year)

I consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician/surgeon under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment.

As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered, I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

These authorizations shall remain effective until September 1, 2009.

\_\_\_\_\_ Date \_\_\_\_\_ Parent or Legal Guardian \_\_\_\_\_ Parent or Legal Guardian

PLEASE PRINT or TYPE

\_\_\_\_\_ ( ) \_\_\_\_\_  
(Last Name) (First Name) (Home Phone)

\_\_\_\_\_ (Street Address) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code)

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Male) (Female) (Birth date)

\_\_\_\_\_ (Parent's Name(s))

GSLC Member \_\_\_\_\_ Guest \_\_\_\_\_

Emergency & Health Information (To be read and completed by parent)

General: Does youth have - (If "yes" - explain)  
Yes \_\_\_ No \_\_\_ Allergies? \_\_\_\_\_  
Yes \_\_\_ No \_\_\_ Heart Condition? \_\_\_\_\_  
Yes \_\_\_ No \_\_\_ Other? \_\_\_\_\_

Is youth subject to - (If "yes" - explain)  
Yes \_\_\_ No \_\_\_ Fainting? \_\_\_\_\_  
Yes \_\_\_ No \_\_\_ Sleep Walking? \_\_\_\_\_  
Yes \_\_\_ No \_\_\_ Upset Stomach? \_\_\_\_\_  
Yes \_\_\_ No \_\_\_ Other? \_\_\_\_\_

Does youth have reaction to - (if "yes" - explain)  
Yes \_\_\_ No \_\_\_ Bee Sting \_\_\_\_\_  
Yes \_\_\_ No \_\_\_ Penicillin? \_\_\_\_\_  
Yes \_\_\_ No \_\_\_ Poison Ivy, Oak, Sumac? \_\_\_\_\_

Yes \_\_\_ No \_\_\_ Other Drugs? \_\_\_\_\_  
Yes \_\_\_ No \_\_\_ Other? \_\_\_\_\_

Please indicate ANYTHING else which leaders should know to help avoid or deal with any situations that may arise: \_\_\_\_\_

Date of last Tetanus shot: \_\_\_\_\_

EMERGENCY INFORMATION: Insurance Company: \_\_\_\_\_ Policy No: \_\_\_\_\_

Emergency Contact People:

Parent's Work Phone \_\_\_\_\_  
Friend/Relative \_\_\_\_\_  
Doctor's Name \_\_\_\_\_

Parent Cell Phone \_\_\_\_\_  
Contact Phone \_\_\_\_\_  
Doctor Phone \_\_\_\_\_

EMERGENCY PROCEDURE: IN EVENT OF ANY EMERGENCY, LEADERS WILL ATTEMPT FIRST TO CONTACT THE PARENT AND/OR DOCTOR. In the event that is impossible, note below:

- \_\_\_ Yes \_\_\_ No 1. With my initial I hereby authorize First Aid by church staff and counselors
- \_\_\_ Yes \_\_\_ No 2. With my initial I hereby authorize emergency medical care by hospital staff and/or doctor selected by church staff or counselor.
- \_\_\_ Yes \_\_\_ No 3. With my initial I hereby authorize physician selected by church staff member to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery.
- 4. If parent has answered "No" to either #1, #2, or #3 above, YOU MUST indicate procedure to be followed in event we are not able to contact parent.

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