

Authorization to Consent to
Medical 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, 2010.

_____ 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 _____ Parent Cell Phone _____

Friend/Relative _____ Contact Phone _____

Doctor's Name _____ Doctor Phone _____

EMERGENCY PROCEDURE: IN EVENT OF ANY EMBERGENCY, 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.