

2011-12 Student Ministries Authorization for Medical Treatment

I, _____, am the parent / legal guardian of

Name of parent or guardian

Name of child

hereinafter, "my child", who was born on ____/____/____. My child participates in regular and/or special

Date of birth

activities at Parkview Evangelical Free Church of Rapid City hereinafter, "Parkview EFC."

In the event that I am not able to be reached at the phone numbers below, I hereby authorize the designated representative of Parkview EFC to consent to medical care or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed 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 authorize the designated representative of Parkview EFC to receive physical custody of my child upon completion of any treatment in the case that I am not available to do so.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and surgeon.

Dated _____, _____

Signature of parent or legal guardian

Additional information

Parent / guardian

Address

City

State

Zip

Home phone

Work phone

Cell phone

Medical / health insurance company

Insurance policy number

Family Physician

Phone number

Date of last tetanus shot

Emergency contact

Relationship to minor

phone #

Secondary emergency contact

Relationship to minor

phone #

Allergies / allergic reaction of my child

Medicine being taken by my child