

Medical Treatment Authorization for Youth Events For Christ Community Church

Minor's Name: _____

Home Address: _____

Date of Birth: ___/___/___

Gender: [] Male [] Female

Medical Information

Primary Care Physician: _____ Phone # _____

Medical Insurance Provider: _____

Policy # _____

Allergies to Medications: _____

Medical conditions for which the minor is receiving treatment:

Prescription drugs the minor is taking:

Other pertinent medical information: _____

Authorization and consent of parent(s) or legal guardian(s) for medical treatment of minors attending youth functions at Christ Community church:

As custodian of the aforementioned minor, I grant my authorization and consent for a designated adult from Christ Community Church to administer general first aid treatment for minor injuries or illnesses. If the injury or illnesses is severe, I authorize him or her to seek professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical care deemed advisable by a licensed medical professional or institution. I authorize the designated adult from Christ community Church to exercise best judgement upon the advice of medical or emergency personnel, if I cannot be reached

Date ___/___/___ (valid for one year) Phone # _____

Parent/Guardian Signature: _____

Parent/Guardian Printed Name:
