Leander Church of Christ Youth Ministry- Parental Consent Form

Subject: Authorization for Medical Treatment of Minor

I give permission for _____ to participate in activities with the Leander Church of Christ youth group. Furthermore, I understand that all safety precautions will be observed, but the church and adult chaperones, youth minister(s), and church leaders, on any phase of the trip or activity, will not be responsible for any accident. I authorize any adult with this group to make decisions regarding the welfare of my child, including but not limited to, x-ray examination, anesthetic, medical, dental, 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, surgeon, or dentist licensed under the Medical Practice Act and/or the Dental Practiced Act for my child. I further agree to pay all charges for the dental, medical, hospital care, treatment, or other expenses incurred.

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 above mentioned expense to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

Name of family doctor:_____

Doctor's phone numbers: Office: _____ Home: _____

Medication being taken (if any): _____

Allergies (food, plants, etc.) or physical problems of which we should be aware and suggested treatment:

_____

_____

Is youth subject to any of the following (if yes, check appropriately):

___ Abscessed Ear ___ Diabetes ___ Poison Ivy ___ Allergies ___ Fainting
___ Rheumatic Fever ___ Sinus Infection ___ Heart Trouble ___ Asthma ___ Bronchitis
___ Kidney Trouble ___ Sleepwalking ___ Lung Trouble ___ Wasp Sting (allergic reaction)
___ Convulsions / Seizures ___ Other (please specify): _____

I give permission for you to give the following to my child, if requested: (please check)

_____ TYLENOL (or Acetomonophen)
_____ ADVIL (or Ibuprofen)
_____ BENADRYL (antihistamine) for bee stings, insect bites, poison ivy, etc.

Date of last tetanus shot: ____/____/_____ Student's Social Security #: _____-_____-_____

Insurance company and policy number _____

Parents: _____

Address: _____

Home phone: (_____) _____-_____ Cell: (_____) _____-_____ , _____-_____

Work: (Father) (_____)_____-_____ (Mother) (_____)_____-_____

Neighbor or relative for emergency contact if parents cannot be reached: (Name & Phone #)

_____

Parent(s) or Legal Guardian(s) Signature: _____

Date of Signature (s): _____