



Parental Authorization for
Emergency Medical Care and Treatment

Trinity Presbyterian Church
September 2008 – August 2009

Name of Minor _____ Birthdate _____

Authorization of Consent to Treatment of Minor:

(We), the undersigned, parent(s) of _____ a minor, do hereby authorize any youth ministry leaders of Trinity Presbyterian Church as agent(s) for the undersigned to 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 specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This Consent and Authorization shall include and extend to all matters of which consent or authorization is required by any hospital, medical care provider or member of the healing arts profession. In consideration of the services which are rendered to my child named above, pursuant hereto, (I) (We) agree to pay for all such services in the same manner and to the same extent as if the same had been personally authorized. This authorization shall be effective with Trinity Presbyterian Church and remain effective through the **31st day of August 2009**, unless sooner revoked in writing delivered to said agent(s).

Without in any manner limiting the foregoing appointment and/or authorization, if circumstances reasonably permit, I/We would like to have our physician consulted in connection with such medical and/or surgical treatment and /or special procedures, said physician being:

Name of Physician: _____ Phone _____
Address _____

Hospital Preference _____

PLEASE FILL OUT BACK AND SIGN.

Health History

School Year _____ Grade _____ Date _____

This information will be held in confidence by the Director of Christian Education/Youth Ministry and the Trinity Presbyterian Church Parish Nurse. It is important that the questions be answered completely and accurately.

Name of Minor _____ Male/Female Birthdate _____

Address _____ Social Security # _____

Parent/Guardian Name _____ Home Phone _____

Mother's Work Phone _____ Father's Work Phone _____

Cell Phone(s) _____ Pager # _____

If a parent cannot be reached at any of the above phone numbers who should we contact in an emergency? _____ Phone _____

Relationship to minor? _____

For the safety and well being of your child, the medical information will be released to all personnel and/or volunteers working directly with your child.

Known Medical Conditions _____

Medications? _____

Other Medications (not being administered on trip) _____

Allergies? _____

Allergy to Medication? YES NO If yes, Type of Reaction _____

Allergy to Bee Stings? YES NO If yes, Type of Reaction _____

Emergency Procedure Needed _____

Last Tetanus Immunizations? _____

Family Physician _____ Phone _____

Insurance Company and address _____

Policy # _____ Group # _____

Signature of Parent/Guardian _____