Authorization to consent to medical treatment for minor child

As the parent/guardian of the child(ren) listed below I / we _____
Parent's / guardian's name(s)

authorize to consent to any x-ray, examination, anesthetic, medical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or specific supervision and on the advice of a licensed physician or surgeon when the need for such treatment is immediate, and when efforts to contact me / us are unsuccessful.

_____
Parent's / guardian's signature Date

Child(ren)'s Information

Name _____ Grade: Sex:

Age: Birth date: Date of last tetanus shot:

Allergies (including medical:) _____

Medicines child is taking (if any): _____

Additional medical information which may be helpful to attending physician:

Name _____ Grade: Sex:

Age: Birth date: Date of last tetanus shot:

Allergies (including medical:) _____

Medicines child is taking (if any): _____

Additional medical information which may be helpful to attending physician:

Name _____ Grade: Sex:

Age: Birth date: Date of last tetanus shot:

Allergies (including medical:) _____

Medicines child is taking (if any): _____

Additional medical information which may be helpful to attending physician:

Please complete other side

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Parent's / guardian's Phone: Home:( ) _____ Work:( ) _____

Cell:( ) _____ Email: _____

Address: _____

Name & address of child's doctor: _____

_____ Phone:( ) _____

Choice of specialists (if any): _____

Insurance Data:Company: _____ Agreement #: _____

Group #: _____ Plan code, etc.: _____

List the names, relationship & phone numbers of 2 people we may contact if we are unable to contact you:

_____

Do you wish to be notified in the event of a minor illness or injury? Yes No

Medical Dispensing

Please indicate by checking the appropriate block and signing below to allow or not to allow the adult advisors of **Z**(ion) **Y**(outh) **M**(inistry) to dispense over the counter medications pertaining to, but not limited to, headache, allergies, and anti-diarrhea to the youth members under their care. Over the counter medications have varied names and are too numerous to mention individually. Some youth are on prescription medications that are requested to be under adult supervision by the parent or guardian. These may also be given to the youth who will take the correct / indicated dosage on the prescription bottle / package.

Yes, I allow the adult advisors of ZYM to give needed medications to my child:

☐

_____

Parent / Guardian signature **Date**

No, I do not want adult advisors of ZYM giving medications to my child:

☐

_____

Parent / Guardian signature **Date**

This form will be kept on file until August 2009 for all youth members and updated as necessary prior to that time.

Please complete other side

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