

PERMISSION SLIP & MEDICAL CONSENT FORM



EVENT NAME _____

I, the undersigned parent or guardian of _____ a minor, do hereby authorize adult workers with the youth of Spanish River Church to consent to any examinations, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care, which is rendered under supervision of any physician or surgeon licensed under the provisions of the medical Practice Act on the Medical Staff of a licensed hospital,, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Further, as parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services. I also guarantee payment of any charges incurred during this medical treatment.

In regard to the above mentioned student, I submit the following information:

- ALLERGIES to any food, medications, etc. (If none, so state)

- SPECIAL MEDICAL problems (If none, so state)

- Is the student on any continuing medication? (if so, state and describe recommended dosage)

- I also give permission for the above adult youth leaders to administer the following medications to help alleviate minor aches and pains that my child may incur:

(please circle) Tylenol ImmodiumAD Motrin Pepto Bismal

Parent or Guardian (Print)

Daytime Phone

Address

Evening Phone

City

State

Zip

Health Insur Company

Policy #

Group #

Signature of Parent or Guardian

Email address

Date