

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

2010-11

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 2011 for all youth members and it is requested that it be updated as necessary prior to that time.

Please complete other side