

Parental Consent/Medical Treatment Form – 2007-08

Smoky Hill United Methodist Church

I, the undersigned parent or guardian of _____, a minor, do hereby authorize adult workers with the youth of the above named church to consent to any examination, 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 emergency 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.

(Please print the following information)

Name of Participant: _____

Parent or Guardian: _____

Insurance Company or Group: _____

Policy Holder and Policy Number: _____

Allergies _____

Exceptions: _____

Does your insurance require a call ahead? _____

Address of insurance company: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Signature of Parent or Guardian

Date