

AUTHORIZATION FOR MEDICAL TREATMENT

I, _____, am the parent or legal guardian of _____ (hereinafter "my child"), who was born on _____, _____ . My child is attending and participating in activities at Embrace Fellowship Church (hereinafter "this camp," "church," "school," etc.) located at: 22825 Antique Lane in the City of New Caney, County of Montgomery, and State of Texas, beginning on the day of _____.

I hereby authorize the (SUPERVISOR/MANAGER/PASTOR/CAMP DIRECTOR) and his/her officers, agents, servants, or employees that are 18 years of age or older, who supervise the activities at this (CAMP, CHURCH, SCHOOL, ETC.) into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize the (SUPERVISOR/MANAGER/PASTOR/CAMP DIRECTOR) and his/her officers, agents, servants, or employees that are 18 years of age or older, who supervise the activities at this (CAMP, CHURCH, SCHOOL, ETC.) to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to the (SUPERVISOR/MANAGER/PASTOR/CAMP DIRECTOR) and his/her officers, agents, servants, or employees that are 18 years of age or older who supervise the activities at this (CAMP, CHURCH, SCHOOL, ETC.).

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the supervisor or his/her authorized designee, in the exercise of his/her best judgment, upon advice of such physician, dentist, and surgeon, may deem advisable.

Dated: _____, 20 ____

(Signature)

(Printed name)

Additional Information:

Parent/Guardian Address

City _____ State _____ ZIP
Code _____

Home Phone No. _____ Work Phone
No. _____

Medical/Health Insurance Company Policy
No. _____

In case of emergency, notify

Relationship to
Minor _____

Emergency Phone No. _____

Allergies/Allergic reactions of my child.

Other information regarding my child's health that a doctor should know.

