Shiloh Baptist Church

Doing Life Together

Medical Consent Authorization

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Medical Provider Information:

Insurance Provider: _____ Policy Number: _____

Physician: _____ Physician's Phone: _____

Physician's Address:

In Case of an Emergency Contact:

_____

Name Phone Relationship

_____

Name Phone Relationship

_____

Name Phone Relationship

Known Allergies:

Medical Problems and Medications:

This information is included to provide information to emergency personnel of medical problems and medications in an emergency situation.

Existing Medical Problem *(Example: Asthma)*	**Medication Taken** *(Example: Combivent)*	**Dosage Taken** *(Example: 2 puffs)*	**Dosage Frequency** *(Example: "Twice Daily")*

Previous Surgeries/Procedures or other relevant Medical Information not listed above:

Medical Consent Authorization:

In the event of an injury, accident, illness or other emergency, and if the above stated physician cannot be reached, I authorize ____ myself _____ my child to be treated by certified emergency personnel such as emergency medical technicians, emergency room physicians and other emergency room personnel such as nurses and laboratory technicians. I agree to accept financial responsibility for the costs related to this medical treatment. I further authorize the staff, members, and/or associates of Shiloh Baptist Church to act in any emergency situation requiring medical attention. I agree to indemnify and hold harmless anyone associated with Shiloh Baptist Church for all medical or dental expenses incurred as a result of participation in any events, ministries, activities, or programs. I hereby acknowledge that Shiloh Baptist Church, its staff, members, or representatives cannot be held responsible for any personal injury to myself or my child. This Authorization is considered valid for one year from the date the Authorization is signed.

_____

Name Date Signed

_____

Name of Authorized Parent or Guardian Date Signed

State of Florida, County of _____

Sworn to and subscribed before me this _____ day of _____, _____
Year

My Commission expires: _____

_____

NOTARY PUBLIC – State of Florida at Large

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