



Children's Ministry - Consent for Medical Treatment

Child's Name: _____ Date of Birth: _____

Address: _____

Parents/Guardians names: _____

Parent/Guardian email: _____

Parent/Guardian phone: _____

Known medical conditions, including food or medicine allergies: _____

Prescription Drugs or Medications taken by child: _____

I request that my child be allowed to participate in Calvary Chapel Morgantown's Children's Ministry Events.

X Signature of Parent/Guardian: _____ Date: _____

Medical Release/Consent For Medical Treatment Form

(Every effort will be made to contact the parent/guardian in the case of accident or illness)

I (We), as the parent(s) or Guardian(s) of the child named above, do hereby authorize Calvary Chapel Morgantown (CCM) and approved children's ministry adult leaders, as agents for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care, which is deemed advisable by a licensed health care provider or licensed medical care facility in the United States of America.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given in advance to provide authority and power on the part of the aforesaid agents to have a specific consent to any and all such diagnosis, treatment or hospital care which is the aforesaid physician in the exercise of his or her best judgment may deem advisable.

This authorization shall remain in effect from _____, 20__ for one year thereafter, unless sooner revoked in writing and delivered to the said agent.

Please list **TWO** contacts and phone numbers in case of emergency (other than the number listed above)

NAME: _____ **Phone #:** _____

NAME: _____ **Phone #:** _____

X Signature of Parent/Guardian: _____ Date: _____