



## Parental Consent/Medical Treatment Form For the period of June 1, 2025 – December 31, 2026

For activities and trips hosted by South Church of the Nazarene Student Ministries.

I, the undersigned parent or guardian of (student name) \_\_\_\_\_  
A minor who's date of birth is \_\_/\_\_/\_\_\_\_, do hereby authorize adult workers with South  
6Church of the Nazarene 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.

Insurance Company or Group: \_\_\_\_\_

Policy Number \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

**(Please print the following information)**

Name of Participant: \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (    ) \_\_\_\_\_ Mobile Phone (    ) \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Signature of Witness (21 years of age or older) \_\_\_\_\_

My signature confirms that I hereby give witness to the proper completion of this form by  
By the minor's parent or guardian.

**ONLY ONE STUDENT PER FORM.**