Consent Form

Name_____ _____
Last First Middle Initial Birth date

Parent/Guardian_____ _____
Home Phone

Address_____ _____
Street City State Zip Cell/Work Phone

Someone to contact if you cannot be reached

Name_____ _____
Home Phone

Address_____ _____
Street City State Zip Cell/Work Phone

Physician's Name_____ _____
Phone

Insurance Company_____ **Policy #**_____

Authorization for Treatment

I hereby give my permission to the medical personnel selected by the Youth Group sponsors and/or chaperones to order x-rays, routine tests, treatment and necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the sponsor/chaperone to secure and administer treatment, including hospitalization for my child as named above.

Signature of parent or guardian_____ _____
Date