AUTHORIZATION FOR MEDICAL TREATMENT

First Church of God—Tallmadge Ohio

I, _____ am the parent or legal guardian of
(NAME OF PARENT OR GUARDIAN OF MINOR),

_____ (hereinafter "my child"), who was born on _____, _____.
(PRINT FULL NAME OF MINOR) (MONTH & DAY) (YEAR)

My child is attending and participating in activities at or affiliated with **FIRST CHURCH OF GOD,** (hereinafter "church") located at: 464 Northeast Avenue in the City of Tallmadge , County of Summit, and State of Ohio, beginning on the day of _____, _____.
(MONTH & DAY) (YEAR)

I hereby authorize the church staff (paid and volunteer) and his/her officers, agents, servants, or employees that are 18 years of age or older, who supervise the activities at this "church" 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 "church" staff (paid and volunteer) and his/her officers, agents, servants, or employees that are 18 years of age or older, who supervise the activities at this "church" 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 "church" staff (paid and volunteer) and his/her officers, agents, servants, or employees that are 18 years of age or older who supervise the activities at this "church".

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.

I understand this authorization for medical treatment shall remain effective until the parent or guardian submits a newly completed authorization form or submits a letter revoking the current authorization.

Initial(s) of Parent or Guardian: 1. _____ and 2. _____

1. _____
(SIGNATURE OF PARENT OR GUARDIAN)

_____
(PRINTED NAME OF PARENT OR GUARDIAN FOR SAID MINOR)

Dated: _____, 2_____.

2. _____
(SIGNATURE OF PARENT OR GUARDIAN)

_____
(PRINTED NAME OF PARENT OR GUARDIAN FOR SAID MINOR)

Dated: _____, 2_____.

Additional Information:

_____ _____
Parent/Guardian Parent/Guardian

_____ _____ _____ _____
Address City State ZIP Code

_____
Home Phone No.

_____ _____ _____
Father's Work Phone No. In case of emergency, notify Relationship to Minor Child

_____ _____
Father's Cell Phone No. Emergency Phone No.

_____
Father's Email Address (PRINT CLEARLY)

_____ _____ _____
Mother's Work Phone No. Medical/Health Insurance Company Insurance Policy No.

_____
Mother's Cell Phone No.

_____ _____ _____
Mother's Email Address (PRINT CLEARLY) Medical Doctor's Name Doctor's Office Phone No.

_____
Allergies/Allergic reactions of my child

_____
Medicine being taken by my child

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

List any restrictions