# CHRIST COMMUNITY CHURCH OF MARATHON COUNTY INC.
## 8100 ALDERSON STREET
## SCHOFIELD, WI 54476
## MEDICAL CONSENT FORM

**MEDICAL CONSENT:**

In case of accident or serious illness or injury, I authorize ________________________to transport my child (via ambulance or private vehicle) to the nearest emergency room.

I/We hereby give my/our consent to the hospital emergency department staff and the doctors on the hospital's medical staff to treat my child. I/We will accept the responsibility for payment for such medical treatment unless covered by our insurance.

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| ______________________________ | ______________________________ |
| Name of child | Child's phone number |
| ______________________________ | ______________________________ |
| Contact person in case of emergency | Contact person's phone number |
| ______________________________ | ______________________________ |
| Additional contact person | Additional person's phone number |
| ______________________________ | ______________________________ |
| Child's Physician | Physician's phone number |

______________________________
Physician's Address

______________________________
Child's Insurance Provider

Child's Allergies or other conditions:__________________________________________________

________________________________________________________________________________

| | |
|---|---|
| ______________________________ | ______________________________ |
| Parent/Guardian | Date |