Gateway Friends Church Youth Group
Parent Consent Form – 2018-2019

Name: _____ Age: _____ Grade: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

If the above cannot be reached in case of an emergency, please notify:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Family Physician: _____ Phone: _____

Address: _____

Date of last tetanus shot: _____

Medical Insurance name & number: _____

Please note any special medical needs/issues: _____

_____

_____

CONSENT TO TREAT

I (We), the undersigned, parents(s) of _____ minor, do hereby authorize the Gateway Friends Church leaders or adults IN CHARGE as agent(s)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, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act by the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

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

This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until December 31, 2019 unless revoked in writing delivered to said agent(s)

DATED: _____

Signature of Parent/Guardian: _____