Authorization for Medical Care of Participant

I, _____, the undersigned parent or person having legal custody or the guardian of _____, DO HEREBY

AUTHORIZE, _____ TO CONSENT to any x-ray examinations, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above named participant under general or special supervision and upon advice of a physician, surgeon or dentist licensed under the laws of the State of Arkansas and Oklahoma.

IN GIVING THIS CONSENT I RECOGNIZE AND UNDERSTAND that in situations where the above named minor requires immediate medical or hospital care, it may not be possible to contact me. In such situations, I will not be able to knowledgeably evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his/her professional judgment and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he/she in his/her professional judgement determines to be necessary for the health and safety of the above named participant.

I also understand this covers consent for all activities for the above named participant through the Arkansas-Oklahoma Synod Lutheran Youth Organization.

_____

(Signature) (Date)

_____

(Address)

_____

(City) (State) (Zip Code)

_____

(Home Phone #) (Work phone #)

_____

(Cell phone #)

_____

(Emergency name) (Phone #)

TREATMENT INFORMATION:

(Insurance name) (Policy #)

(Physician name) (Physician phone #)

(Participants Birthdate) (Date of last Tetanus shot)

(Any known allergies)

(List medications participant is currently taking)

(Participant's pertinent medical history)