LEANDER CHURCH OF CHRIST YOUTH MINISTRY - PARENT CONSENT FORM

Subject: Authorization for Medical Treatment of a Minor

I give permission for _____ to participate in activities with the Leander Church of Christ and it's youth group. Furthermore, I understand that while all safety precautions will be observed, the church and adult chaperones, youth minister(s), and church leaders, on any phase of the trip or activity, will not be responsible for any accident. I authorize any adult with this group to make decisions regarding the welfare of my child, including but not limited to, x-ray examination, anesthetic, medical, dental, 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, surgeon, or dentist licensed under the Medical Practice Act and/or the Dental Practice Act for my child. I further agree to pay all charges for the dental, medical, hospital care, treatment, or other expenses incurred.

As a parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the above mentioned expense to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

Primary Care Physician (PCP): _____ PCP Office #: _____

Current Medications & Instructions: _____

_____

Known allergies or physical problems we should be aware and suggested treatments: _____

_____

I give permission for the following OTC medications to be given to my child, if requested:

❏ TYLENOL (Acetaminophen) ❏ ADVIL (Ibuprofen) ❏ BENADRYL (Antihistamine)

Date of Last Tetanus Vaccine: _____/_____/_____

Is youth subject to any of the following (check all that apply):

❏ Abscessed Ear	❏ Convulsions/Seizures	❏ Kidney Trouble	❏ Sinus Infections
❏ Allergies	❏ Diabetes	❏ Lung Trouble	❏ Sleepwalking
❏ Asthma	❏ Fainting Spells	❏ Poison Oak / Ivy	❏ Other (please specify):
❏ Bronchitis	❏ Heart Trouble	❏ Rheumatic Fever	_____

Insurance Company: _____ Policy #: _____

Group ID/Name: _____ Phone #: _____

Student's Social Security #: _____-_____-_____

Parent / Legal Guardian Names: _____

Address: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Email Address: _____

Emergency Contact Name & Phone: _____

Parent / Legal Guardian Signature: _____ **Date:** _____

Please submit a picture or copy of the front and back of your family's insurance card along with this form.