Your son or daughter will need this on file or with them for any day trip, retreat, mission trip or camping experience
Send it in and we will keep it on file

Parental Consent for Medical Treatment of Minor

We, the undersigned, are the parents or legal guardians of the child named below and we have temporarily entrusted the child to the care of Christ Church, PCA and its adult staff members and volunteer leaders. In the event that he or she is injured and requires the attention of a doctor, we consent to any reasonable medical treatment as deemed necessary by a licensed medical care provider, licensed within the state or country where the services are to be performed In the event treatment is called for, which a physician and or hospital personnel refuses to administer treatment without our consent, we hereby authorize Christ Church, PCA and the adult members of its staff or its volunteer leaders to give such consent for us if we cannot be reached by telephone at one of the numbers indicated below or, because of an emergency, there is not time or opportunity to make a telephone call. **Special medical care information for the child is on the reverse side of this form.**

The parent(s) or guardian(s) authorize any hospital that has provided treatment to the child to return physical custody of the child to Christ Church, PCA and its adult staff members or its volunteer leaders when treatment is completed.

The parent(s) or guardian(s) agree to fully pay for any and all costs of medical or dental care provided to the minor and consented to by Christ Church, PCA and/or its adult staff members or its volunteer leaders. **Medical insurance information is on the reverse side of this form.**

In the event it becomes necessary for Christ Church, PCA and/or its adult staff members or its volunteer leaders to give consent for us, we agree to hold Christ Church, PCA and its adult staff members and its volunteer leaders free and harmless of any claims, demands, or suits for damages arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed medical care provider.

THIS AUTHORIZATION SHALL REMAIN EFFECTIVE UNTIL REVOKED IN WRITING AND DELIVERED TO CHRIST CHURCH, PCA

Name of Child (please print): ____

Emergency Telephone Numbers: ____

Parent or Guardian Signatures:

_________________________________Relationship: _____________________Dated: _______

_________________________________Relationship: _____________________Dated: _______

Please fill out both pages and return to:

Christ Church, PCA
2500 Breton Rd. SE
Grand Rapids, MI 49546
(616) 949-9630

Medical information

Doctor's Name: ____

Doctor's Address: ____

Doctor's Telephone Number: ____

Listed Allergies: ____

____

Medication currently being taken: ____

____

____

Date of last Tetanus Shot: ____

Physical Impairments: ____

Other pertinent facts to which the treating physician should be alerted:

____

____

____

Insurance Information

Insurance Company: ____

Contract #: ___________________________Group Policy #: ______________________________

Claim Office Telephone Number: ____

Claim Office Address: ____

Employer Name and Address: ____

____

Employer Telephone Number: ____