Consent To Treat – Minor

SOULED OUT

High School Ministry

I hereby consent to any x-rays, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. In the event I cannot be reached in an emergency, I give permission to the activity leader(s) to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my child. I understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care. Further, as parent or legal guardian I hereby agree that I am financially responsible, either personally or through my health insurance plan, for any dental, medical, or hospital care or treatment that is given to my child. Any policy of Cornerstone Community Church will be used as secondary coverage.

Executed at ____ California, on: __________________
(City) (Date)

____ _______________________________
(Parent/Legal Guardian's Name-PLEASE PRINT) (Phone Number)

____ ( ) Parent ( ) Legal Guardian
(Signature)

Parental/Guardian signature is required for participants under 18 years of age.

This consent form shall remain in effect for one year from the date signed.

Minor's Last Name_____________________________ First Name_______________________ Sex _______

Address_____________________________________ City_________________ State______ Zip_________

Home: (______) ________________ Cell: (______) ________________ Work: (______) ______________

Date of Birth: ________________________________

Medical Insurance Information

Insurance Company:___________________________ Phone Number:(_______)_____________________

Policy Number:_______________________________ Group Number:______________________________

Doctor's Name:_______________________________ Phone Number:(_______)_____________________

Dentist's Name:______________________________ Phone Number:(_______)_____________________

Emergency Contact Information

Name:_____________________________________ Name:_______________________________________

Relationship:_______________________________ Relationship:_________________________________

Home Phone:(_______)________________________ Home Phone:(_______)_________________________

Cell/Pager: (_______)________________________ Cell/Pager:(_______)__________________________

Work Phone:(_______)________________________ Work Phone:(_______)_________________________

Health History

Allergies (medicine, food, etc.): ____

Medications being taken: ____

Physical Impairments: ____

Date of last tetanus shot: ______________________