

Authorization for Medical Treatment

As the parent and/or legal guardian, I do hereby authorize medical treatment for each of the following minor children in the event of a medical emergency (**please indicate each child's full name on line below**):

This Authorization shall be valid for a period of one year from the date of signature. A photocopy of this Authorization shall be as valid as the original

Signature of parent or guardian

Date

Another person to contact in case of emergency

Name/relationship: _____

Phone: _____

Medical information: (allergies, diabetes, medications, etc.)

Name: _____

Comments: _____

Treatment: _____

Special learning needs:

Name: _____

Comments: _____

Please consider joining us in this ministry.

- Are you are over the age of 18?
- Do you desire to learn more about the faith?
- Do you enjoy working with youth?
- Do you like having fun?

*If so, then check the box, and we will meet up with you for further discussion.

Yes, I would like to help/want more info.