

Community Baptist Church & Christian Schools 2011 – 2012 Consent for Emergency Medical Treatment of a Minor Child

I/We _____ and _____
Name Name

of _____
City County State

do hereby state that I am (we are) the parent(s) or legal guardian(s) of:

_____, age _____ Grade in **Fall '11** _____
Name

born _____, who resides with me (us) at _____
Date

Street address, City, State

I (We) authorize **Community Baptist Church & Christian School Staff,**

An adult over 18 years of age, who works at 5715 Miami St.

In the city of South Bend, St. Joseph County, Indiana

To consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above named minor under the general or special supervision and on the advise of any physician or surgeon licensed to practice medicine in the United States of America.

For the period from June 1, 2011 – May 31, 2012.

Dated this _____ day of _____, 2011.

Signatures of parent(s) or guardian(s)

Witness _____ Witness _____

FAMILY DOCTOR _____

Phone _____

Medical Insurance Carrier _____

Identification Number _____

Member's Name _____

Benefit Code _____

Account Number _____

Student's Social Security Number _____

MEDICAL HISTORY

Allergies, if any, including medication and foods: _____

Chronic or existing diseases or medical problems (e.g.: diabetes, epilepsy): _____

Medicines your child is taking now and dosage: _____

Date child received last Tetanus injection or booster: _____

In an emergency, parents can be reached as follows: Home No.: _____

Work No. Father: _____ Work No. Mother: _____

Cell No. Father: _____ Cell No. Mother: _____

If a parent cannot be reached, contact: _____

Phone Number: _____

