

Attach Copy of
Insurance Copy

THIRD EPISCOPAL DISTRICT TAWAWA 2011
July 11, 2011 – July 14, 2011--- Wilberforce University

YOUTH PERMISSION AND MEDICAL AUTHORIZATION FORM

Name _____
Last First Middle Initial Age

Home Address _____ Home Telephone _____
Street Apt#
City State Zip Cell Phone _____

Church _____ Pastor _____

✓ **Parent/Guardian Information**

Father's Name (or Guardian) Place of Employment Business Phone Cell Phone

Mother's Name (or Guardian) Place of Employment Business Phone Cell Phone

✓ **Emergency Contact – Two Persons to be called in event that Parent/Guardian cannot be reached.**

Name Phone

Chaperone's Name Cell Phone

✓ **Medical Authorization**

Parents/Guardian give permission to provide emergency treatment for children who become ill or injured while under church authority, when parents/guardians cannot be contacted. Part I or II **MUST BE COMPLETED.**



EMERGENCY INFORMATION



MEDICAL AUTHORIZATION

INSURANCE COMPANY _____ CARD NUMBER _____

Part I. Granting Medical Consent - If reasonable attempts to contact me, other parent, or guardians, have been unsuccessful, I give my consent for:

- Administration of Treatment deemed necessary by resident doctor or dentist
Dr. _____ or Dr. _____
- Transfer my child to _____, the resident hospital. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the need for such surgery, are obtained prior to the performance of such surgery.

Please check/list applicable medical conditions: Allergy Asthma Bleeder Convulsion Fainting Spells
 Heart - Other (specify): _____

Medications: _____

Signature of Parent/Guardian _____ Date _____

Part II. Refusing Medical Consent - I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I want authorities to take no action or to: _____

Signature of Parent/Guardian _____ Date _____