MEDICAL TREATMENT AUTHORIZATION FORM

FULL NAME OF MINOR_____
HOME ADDRESS _____
BIRTHDATE _____ GENDER male____ female____

NAME(S) OF PARENT OR LEGAL GUARDIAN _____
_____
ADDRESS _____
HOME PHONE _____
WORK PHONE _____
CELL PHONE _____

PHYSICIAN'S NAME _____
PHYSICIAN'S PHONE NUMBER _____
ALLERGIES TO MEDICATIONS_____
OTHER ALLERGIES _____
MEDICATIONS
_____
_____

ALL CONDITIONS FOR WHICH THE CHILD IS RECIEVING TREATMENT
_____
_____
_____
IMPORTANT PAST MEDCIAL HISTORY
_____
_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I _____ , the parent or legal guardian of (minor's name) _____ give my authorization to staff members of Presbyterian Church of the Cross to give first aid to the above minor in case of minor injuries such as scrapes and bruises. In case of more serious injury or illness, attempts will be made to contact me. In case of a life threatening medical emergencies I authorize staff at Presbyterian Church of the Cross to seek emergency medical treatment for the minor listed above, including transportation by ambulance to an emergency medical facility.

SIGNATURE
PRINTED NAME
DATE