

Flipside Student Ministries Medical Consent Form
Authorization to consent to Medical Treatment for a Minor
Child at any Medical Facility.

Date: _____

Authorization is hereby given to Josh Taylor, Family Pastor at Faith Fellowship Church, for consent to emergency treatment for my child, _____ and to proceed with such treatment that may be necessary, in that we, the parents or guardians, are not available at the time of injury. Also, in our absence, authorization is given for admission to the hospital at time of injury or illness, if admission is advised by our private physician or a consulting physician of his office.

ALL MEDICAL INFORMATION MUST BE COMPLETELY FILLED IN

Child's Birthdate ____/____/____

Date of last Tetanus Shot: ____/____/____
 (Booster is required every 10 years)

Allergic to any medications? If yes, please list _____

Allergies: _____

Chronic Illness: _____

Current Medications - Please list each medication with schedule & dosage taken.

<u>Medication</u>	<u>Time</u>	<u>Dosage</u>	<u>Medication</u>	<u>Time</u>	<u>Dosage</u>

Full name of child's Primary Care Physician: _____

Telephone: _____ Doctor's Exchange: _____

Address & telephone number where parents/guardians may be reached: (Please include work, cell & pagers) _____

(Please list a name by each phone number)

Emergency contact in case parents cannot be reached. (Please list name, phone number and relationship to child):

As parents/guardians, we promise to pay whatever costs are not covered by:

Name of Insurance: _____

Policy/Group Number: _____

Phone Number _____

 Parent/Guardian's Signature