

PARENTAL CONSENT FORM

NAME _____ AGE _____ BIRTHDATE ____ / ____ / ____

ADDRESS _____ PHONE(____) _____

CITY _____ STATE _____ ZIP CODE _____

SCHOOL _____ GRADE IN OR JUST COMPLETED _____

PARENT(S) BUSINESS PHONES _____

I/We authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical or dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for my/our child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for my/our child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by Eugene First Nazarene.

Please note: If a serious emergency arose, it might be necessary for a physician to attend to your son/daughter before the staff could get in touch with you or your designated physician.

HOSPITAL INSURANCE Yes _____ No _____

Insurance Company _____

Policy Number _____

Participant

Father

Mother

Legal Guardian

In Case of Emergency Contact:

1. _____

2. _____

I hereby authorize that emergency medical and/or surgical care may be provided for my son/daughter from 1/1/2008 to 12/31/2008 (one year) inclusive.

Parent/Guardian Signature

HEALTH INFORMATION

Health Information Necessary for Proper Care and Protection

- 1. Describe any health factor that makes it advisable for your son or daughter to limit physical activity on the trip: _____
- 2. Please state any limitations: _____
- 3. Any known allergy to medication? _____
- 4. Directions for medication to be brought on the trip: _____

- 5. May have aspirin if needed? _____ Aspirin substitute? _____
- 6. Do any foods cause allergic reaction? _____
- 7. Do you object to our insistence of eating the basic daily diet? _____
- 8. Is there something else we should know about your son/daughter? _____

9. Check any conditions your son/daughter might have:

HEART	DIET	LUNGS	OTHER
<input type="checkbox"/> heart surgeries	<input type="checkbox"/> diabetes	<input type="checkbox"/> asthma	<input type="checkbox"/> allergies
<input type="checkbox"/> bypasses	<input type="checkbox"/> hypoglycemia	<input type="checkbox"/> emphysema	<input type="checkbox"/> epilepsy
<input type="checkbox"/> heart medication	<input type="checkbox"/> diet restrictions	<input type="checkbox"/> high altitudes	
<input type="checkbox"/> pacemaker	<input type="checkbox"/> prescribed insulin		prescribed medications:
<input type="checkbox"/> high blood pressure			_____

10. Date of your son/daughter's last Tetanus shot: ____/____/____

COMMENTS:

(Please include any additional information we should be aware of in case of any emergencies.)
