



# **MEDICAL CONSENT FORM**



\*To be completed by student **OR** parent/guardian if student under 18

**Student Name(s):** \_\_\_\_\_

## **CONTACT INFORMATION**

### **Person to be contacted first in case of emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

### **Closest relative or neighbor to contact if above cannot be reached:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phones: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

### **Family Physician:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

### **Home Church:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Pastor: \_\_\_\_\_

Address: \_\_\_\_\_

## **INSURANCE AND/OR MEDICAL ASSISTANCE INFORMATION**

Name of Company: \_\_\_\_\_

Address: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student's Date(s) of Birth: \_\_\_\_\_

## **ADDITIONAL INFORMATION**

Special medical or dietary information necessary for management in an emergency situation:

\_\_\_\_\_

Student **OR** Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **AUTHORIZATION FOR THE TREATMENT OF A MINOR CHILD**(complete only if student(s) under 18)

I \_\_\_\_\_ (parent/guardian) hereby authorize the personnel of Creative Expressions and Church At The Heights to give consent for emergency medical care and/or treatment to the closest hospital for \_\_\_\_\_ (child/children) while under the supervision of the program's personnel. I also agree to be responsible for all of the costs and fees contingent on any emergency medical treatment for my child secured under this consent.

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

We recommend and ask that your signature be on file with your physician authorizing him/her to care for your child in case of an emergency. Every effort will be made to notify parent/guardian immediately in case of emergency.