

Westminster Presbyterian Church  
2009-2010 Calvin Fellowship

## MEDICAL CONSENT FORM

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State Zip code

Phone Numbers \_\_\_\_\_

Social Security Number \_\_\_\_\_ Current Grade \_\_\_\_\_

To whom it may concern:

The undersigned does hereby give permission for our (my) child,  
\_\_\_\_\_ to attend and participate in the **Calvin Fellowship Program** sponsored by **Westminster Presbyterian Church, September 2009 through August 2010.**

We (I) authorize the adult advisors, 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 physicians or at said hospital. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) 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 our (my) child to ride in any vehicle designated by the adult advisors in whose care the minor has been entrusted while attending and participating in activities sponsored by Westminster Presbyterian Church.

Hospital Insurance  Yes  No

Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**FORM CONTINUES ON REVERSE SIDE**

Please list all medications your child takes on a regular basis, the purpose of the medication and the dosage:

Please list any medical conditions (asthma, diabetes, etc.) your child has that we should be aware of, along with instructions for handling the condition.

May we give your youth non-aspirin pain medication if they request it? \_\_\_ Yes \_\_\_ No  
If you answered yes, what dosage \_\_\_\_\_

Please list all allergies.

Please list anything that will limit your child's participation in planned activities, along with any other information you feel we should have.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Father's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian's Signature

\_\_\_\_\_  
Date