Westminster Presbyterian Church of Snellville, Georgia
Consent for Emergency Treatment, Diagnostic Testing and/or
Admission to Appropriate Hospital/Medical Facility

I,________________________________,hereby, consent for_____________________________________
(Name of Custodial Father/Mother or Legal Guardian) (Youth Leader's Name)

to give permission for the necessary medical services, treatment and procedures performed by physicians, employees of the hospital and or health care personnel, in training as ordered by and under the supervision of the attending physician, or supervised by authorized hospital personnel for :

_______________________________________ while on an authorized trip with Westminster Presbyterian Church of Snellville, GA
(Name of Youth)

I hereby acknowledge that no warranty or guarantee have been made to me as to the effect of such examinations or treatment on the child's condition. I acknowledge that I am financially responsible for all charges in connection with care and treatment rendered to:

____
(Name of Youth)

Signature:____/________________________________
(Custodial Mother or Legal Guardian) (Date)

Signature:____/________________________________
(Custodial Father or Legal Guardian) (Date)

State of____________________________

County of__________________________

Notary Required!!!!!!

Taken, subscribed and sworn to before me, a notary public
In said country, this ________day of___________20____.
My Commission expires___________________________.

____
(Notary Public Signature)

Important Instructions for Completion/Use of Consent for Treatment Form:

1. The Custodial Father and Mother or Legal Guardian **must sign** the form in the presence of a Notary Public.
2. This form **will not be accepted** if not notarized by legal notary.
3. Form must accompany patient at time of treatment.
4. **A copy of Custodial Father/Mother or Legal Guardian's Medical Insurance Card must be attached. (both sides)**

Please complete Information on reverse side for treatment purposes.
Important Information for Treatment

Youth **Full** Name____
Home Address____
City______________________________________State__________________Zip Code__________________
Home Phone____ Cell______________________________________
Youth Date of Birth____
Father's **Full** Name____Employer____________________
Father's Date of Birth____
Telephone Business_________________________________Cell_______________________________________
Mother's **Full** Name____Employer____________________
Mother's Date of Birth____
Telephone Business______________________________ _____Cell_______________________________________

Medical Insurance Information

Personal Health/Accident Insurance Carrier____

Policy #____ Group #_______________________________________

Policyholder Name____
(Copy of Insurance Card attached/required)

Emergency Contact Information

Person to contact in case of emergency____
Phone numbers: home: ________________________Cell:__________________________Work:_______________
Relationship____
Family Physician____Telephone______________________________

Information Needed for Youth Participant

Youth Full Name____ ______________Birthday_____________________
List specific medical problems:____
____
List all allergies:____
____
List all medications (prescriptions/OTC drugs):____
____
List any medical conditions/history that we should be aware of:____
____

Date of Last Tetanus:____________________________(**required information**)
Are Immunizations up to date? ____________________(date of last immunizations)
(Copy of Immunization Record required for all trips)