

**PARENTAL AUTHORIZATION  
TO CONSENT TO MEDICAL TREATMENT**

**Des Moines Gospel Chapel, Youth Department**  
21914 7th Avenue S, Des Moines WA 206-878-2145

\_\_\_\_\_  
(Print name of "MINOR" attending JUNIOR HIGH YOUTH EVENT.)

\_\_\_\_\_  
(Print name of PARENT or Legal Guardian)

In case of emergency, every effort will be made to contact a PARENT or guardian of the MINOR named above.

The above named PARENT of the MINOR has entrusted the MINOR into the care of the JUNIOR HIGH YOUTH GROUP, while the MINOR participates in an activity sponsored by the JUNIOR HIGH YOUTH GROUP, and for the welfare of the MINOR.

The PARENT does hereby authorize the JUNIOR HIGH YOUTH GROUP directors to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the laws of the State or County in which the medical care is being sought and on the medical staff of any hospital.

1. I, the undersigned, legal guardian of \_\_\_\_\_, a minor, do hereby authorize, as agent(s), the adult supervisor of Des Moines Gospel Chapel, to consent to any diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician, surgeon and/or by a dentist. It is understood that this authorization is given an advance of any specific care being required, but it is given to provide authority to give care which a physician may, in the exercise of his/her best judgment, deem advisable.
2. I hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to my above named agent upon completion of treatment.
3. I hereby release Des Moines Gospel Chapel and any other parties from liability in case of accident.
4. I hereby request the above named agent to carry out discipline deemed necessary for my child. I also agree to pay the expenses of my child's trip home because of any disciplinary action.
5. These authorizations shall remain effective until revoked in writing delivered to said agent.
6. **I hereby authorize Des Moines Gospel Chapel to use youth ministry photographs or video to be used for publication.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Circle One: Parent Legal Guardian Person having legal custody

Please complete other side!

**Medical Release**

Although this is a lengthy form, we need to have the information listed below in case of an emergency. Thank you for taking the time to fill this out.

Please complete **BOTH SIDES** of this form for EACH student attending **A JUNIOR HIGH YOUTH EVENT**.

STUDENT'S INFORMATION:

Name \_\_\_\_\_ Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_ Name & Phone No. of closest relative \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ ID # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Grade in Fall of '09 \_\_\_\_\_ Age \_\_\_\_\_ (Circle one) M / F If your child is coming with a friend or sibling, what is his/her name?

Medical information: Please check and specify if any past history of  
\_\_\_\_\_ Allergies \_\_\_\_\_ Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Condition \_\_\_\_\_ Hypoglycemia  
\_\_\_\_\_ Epilepsy or other nervous disorder \_\_\_\_\_ Stomach upsets or disorders

Other illnesses or medical conditions / Comments  
\_\_\_\_\_

What drugs, if any, is your child allergic to? \_\_\_\_\_

Date of last tetanus shot? \_\_\_\_\_ List any known allergies that may impact your child. \_\_\_\_\_ Any dietary or other activity restrictions? \_\_\_\_\_