PERMISSION FOR MEDICAL TREATMENT

LONE OAK CHURCH OF CHRIST YOUTH ACTIVITIES

TO WHOM IT MAY CONCERN: I, the undersigned, being the parent, legal guardian or legal next-of-kin of:

____

(Fill in full name)

hereby authorize any necessary medical treatment for this person while participating in church activities. I also guarantee payment of all charges incurred during the treatment. (Ambulance, physician, hospital, x-rays, lab, drugs, etc.)

In regard to such person, I submit the following information:

1. ALLERGIES TO FOODS, MEDICATION , ETC. (If none, so state; if yes,specify)

   ____

2. Special medical problems (If none so state, if yes specify):

   ____

3. If the student now under medical care? If so, describe nature of illness and treatment:

   ____

4. Does participant carry medication on person? ______________________________
   (If none, so state) Name of medication:______________________________

5. Date of last Tetanus: ______________________________
6. Family physician/clinic: ______________________________

   Phone: ____________________ Office Address______________________________

SIGNATURE OF PARENT or
LEGAL GUARDIAN______________________________ Date____________________

Print or type name of person signing ______________________________
Relationship of person signing______________________________

Residence Address______________________________Zip______________

Home Phone____________________Business/Mother________________Business/Father_____________

Emergency Name and Numbers if above is not available______________________________

Insurance Company: ______________________________

Policy #: ____________________________ Notary:______________________________

Commission Expires:____________________________