Who: 7th -12th

# Event Name here_____

Valley Mills Christian Church

Parental Consent/medical Treatment form

Student's Name:_____

Name of Parent/Legal Guardian: _____

Address: _____

City/State: _____Zip: _____

Phone: _____

Parents' Cell Numbers: _____Text? Y/N _____

Student Cell Number: _____Text? Y/N _____

Please Read Carefully and Sign Below:

I, the undersigned parent or guardian of _____, a minor, do hereby authorize adult workers with the youth of Valley Mills Christian Church to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon 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 physician or at said hospital.

Further, as a parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital, or other medical center for regarding such services. My signature confirms that I hereby give witness to the proper completion of this form by the minor's parent or guardian.

_____

(Signature of Parent or Legal Guardian)

_____(Date)

**IN CASE OF EMERGENCY: Who to contact first (name/ number):_____**
Emergency Phone Numbers and Names other than those listed above

Who: 7th -12th

_____
_____
Insurance Company_____
Policy Number_____
Please list any allergies or medications your student is currently taking, and list *__ANYTHING__ Student Ministry needs to be aware of regarding your student, custody issues, health issues, etc.:
Allergies:_____
_____
_____
Medications:_____
_____
_____
***Issues to be aware of**:
_____
_____