

To Whom It May Concern:

I am giving my consent for medical treatment for my child, \_\_\_\_\_, in the case that I cannot be reached. I give permission to the adult group of leaders and chaperones representing East Maiden Baptist Church to seek the appropriate treatment as deemed necessary by them. Below is important information concerning my child. I understand that this form is valid for one year from the date printed below.

Signed,

\_\_\_\_\_  
Date: \_\_\_\_\_

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Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_

Parent(s) Work Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Child's Doctor: \_\_\_\_\_ Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Medication currently being taken my child: \_\_\_\_\_  
\_\_\_\_\_

All known allergies: \_\_\_\_\_  
\_\_\_\_\_

Any medical conditions: \_\_\_\_\_  
\_\_\_\_\_

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

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