Youth Ministry Authorization To Consent To Treatment

(I), (We), the undersigned, parent(s), guardian(s) of _____a minor, do hereby authorize Calvary Chapel Bible Fellowship, its staff or representatives, as agent(s) for the undersigned to consent to an 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 supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the Medical Staff of any hospital or medical clinic whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. (Allows parent(s) or guardian(s) to authorize any adult to consent to medical or dental treatment as stated in paragraph No. 1 above.)

This authorization shall remain effective until _____, _____, unless sooner revoked in writing delivered to said agent(s).

Dated: _____ **X** _____
Father or Legal Guardian

X _____
Mother or Legal Guardian

For Patient's Protection

1) ALLERGIES AND SENSITIVITIES: Is there a history of skin or other outward reaction or sickness following injection or oral administration of:

	Circle one		If Yes, Describe
(a) Penicillin or other antibiotics	yes	no	_____
(b) Morphine, codeine, Demerol, or other narcotics.	yes	no	_____
(c) Novocain or other anesthetics	yes	no	_____
(d) Aspirin, ibuprofin or other pain remedies	yes	no	_____
(e) Sulfa drugs	yes	no	
(f) Tetanus antitoxin or other serums	yes	no	_____
(g) Adhesive Tape	yes	no	_____
(h) Iodine or merthiolate	yes	no	_____
(i) Any other drug or medication	yes	no	_____
(j) Any foods; i.e.- eggs, milk, chocolate, etc.	yes	no	_____
			_____

1) DRUGS TAKEN RECENTLY: Within the past six (6) months has the patient taken:

(a) Cortisone	yes	no	_____
(b) ACTH	yes	no	_____
(c) Anticoagulants	yes	no	_____
(d) Tranquilizer	yes	no	_____
(e) Hypotensives (high blood pressure medicines)	yes	no	_____

2) Has the patient ever received treatment for Asthma, Rheumatism, or Rheumatic Fever? Yes No

3) When was your child's last Tetanus shot? _____

4) Doctor:_____ Drs. Phone_____

5) Any known medical problems:_____

ChildsName_____Age_____DOB_____Sex_____

Home Address_____

Fathers name_____ Mothers name_____

Phone_____ Emergency Phone_____

I will not hold Calvary Chapel Bible Fellowship, its employees, officers, or agents responsible for any expenses that may occur form accidents or injuries to my child (named above). I further understand that any and all expenses that may occur from any accident, or injuries are the sole responsibility of we the parent(s) and/or guardian(s).

X_____ _____
Parent or Legal Guardian Date

Insurance Company:_____ Policy# or ID#: _____