Mt.Zion Baptist Church

Lifting up Christ • Building up Lives

PARENTAL CONSENT / MEDICAL TREATMENT FORM

Today's Date ______ This form is valid for one (1) year from this date. (Please print the following information)

PARTICIPANT'S INFORMATION

Participant's Full Name LAST FIRST MIDDLE Preferred Name ______

Date of Birth DAY MO YR Age ______ Grade ______ School ______ ☐ Male ☐ Female

Address ______ City ______ State ______ Zip ______

Cell Phone ______ Home Phone ______

Email ______

PARENT (LEGAL GUARDIAN) INFORMATION

Resides with ☐ Mom and Dad ☐ Mom ☐ Dad ☐ Guardian's Full Name LAST FIRST MIDDLE

Name ______ Name ______

Cell Phone ______ Cell Phone ______

Home Phone ______ Home Phone ______

Email ______ Email ______

Address ______ Address ______

City, State, Zip ______ City, State, Zip ______

* if different than above

MEDICAL CONTACT INFORMATION (In case of emergency contact)

☐ Mom ☐ Dad ☐ Guardian ☐ Other LAST FIRST MIDDLE Phone ______

Insurance Company or Group ______ Policy # ______

Physician's Name ______ Phone ______

Hospital Preference ☐ Baptist Health Paducah ☐ Mercy Health

MEDICAL INFORMATION

List all medications currently taking ______

Allergies, Medical Concerns, or other pertinent information: (please include what to do in case of allergic reaction)

______

MEDICAL TREATMENT CONSENT

I, the undersigned parent (or guardian), in the event medical treatment is required and I cannot be reached, give my permission to Mt. Zion Baptist Church Children's or Student Ministry (or an adult sponsor) to secure the services of a licensed physician to provide the care necessary including: anesthesia or surgical diagnosis/treatment, for my child's well-being. I agree to be responsible for the costs and expenses incurred in connection with such medical services rendered to my child pursuant to this authorization, and will not hold Mt. Zion Baptist Church liable.

Printed Name ______ Signature ______

☐ Mom ☐ Dad ☐ Guardian / Relationship ______