PARENT OR LEGAL GUARDIAN CONSENT TO TREAT A MINOR

Being the parent or legal guardian of ______________________________ (minor's printed name), I ______________________________ (parent/guardian's printed name) do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment including providing information included on the *Permission To Dispense Prescribed Medication* and/or *Permission To Self-Administer Prescribed Medication* and/or *Permission To Dispense Non-Prescription Medication* form/s if applicable. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian, I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child. Any policy of the church or organization sponsoring this event will be used as the secondary coverage.

Minor's date of birth: ______________________________

Parent/Guardian Signature: ______________________________ Date: ____________

Medical Insurance Company: ______________________________

Medical Insurance ID or Group #: ______________________________

Medical Insurance Company Phone #: ______________________________

Primary Care Physician: ______________________________

Primary Care Physician Phone #: ______________________________