

Medical Treatment Authorization and Consent

I, _____ [Full Legal Name of Parent/Guardian], being the [parent/legal guardian] of _____ [Child's Full Name] authorize **Agent of Liberty Baptist Church** to seek, obtain and consent to [routine medical care and treatment/emergency medical care and treatment/surgery/hospitalization/blood transfusions/dental care and treatment/other] for _____ [Child's Full Name] as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of **Liberty Baptist Church**, my child's church and is effective until _____ (Date)

Child's Information

Child's Full Name: _____
Address: _____
Date of Birth: _____ Age: _____

Parent/Guardian's Information

Parent's/Guardian's Name 1: _____
Address: _____
Phone Number (H): _____ Phone Number (C): _____

Parent's/Guardian's Name 2: _____
Address: _____
Phone Number (H): _____ Phone Number (C): _____

Child's Health Information

Health Conditions (e.g. Asthma, Diabetes): _____
Allergies (e.g. to Medications, Food): _____
Prescription Medications: _____
Date of Last Tetanus Injection/Booster: _____

Child's Medical Care and Insurance Information

Physician/Pediatrician: _____ Phone Number: _____
Dentist/Orthodontist: _____ Phone Number: _____
Preferred Medical Facility: _____
Insurance Company: _____
Policy/Group Number: _____ Policy Holder: _____

SIGNATURE OF PARENT/GUARDIAN

Signature _____ Date _____
Print Name _____

WITNESS

Witness Signature _____ Date _____
Print Name _____
Address _____

Witness Signature _____ Date _____
Print Name _____
Address _____