Consent to Treatment (Health Form)

Only designated staff will have access to the completed form. This form will be stored in a locked file. This form must be filled out at the beginning of each club year's calendar. A copy of each club member form must be taken on field/conference events. The official waiver must be filled out together with the form.

Club member Full Name: _____

_____ _____

Age Date of Birth (month/day/year) Social Security Number *** (Last 4 numbers ONLY)

Address: _____

Parent/Guardian Information:

Father/Guardian: _____

_____ _____ _____

Home Phone Cell Phone Email

Mother/Guardian: _____

_____ _____ _____

Home Phone Cell Phone Email

Please describe allergies to substances and medications:

_____

_____.

If on regular medication, please specify: _____ _____

Date of Last Tetanus Shot

Please give the name of your local family physician to be called in case your child becomes ill or has an accident during regular club/conference activities and you cannot be reached:

_____ _____

Family Physician Name Office Phone

Physician's Office Address: _____

Hospital Preference: _____ _____

Hospital Phone

Please give the name of a relative or friend who has consented to assume the responsibility of your child in case of illness or accident until you can be reached. In case of any changes in the named person, notify the club in writing.

Name:_____ _____

Phone

Address: _____

The above named student is _____ is not _____ covered by health insurance.

_____ _____

Present Health Insurance Company **Policy Number**

I hereby authorize the Club Ministry Staff to render first aid and/or secure medical treatment s/he deems necessary for myself/my child/my family members if necessary. I give permission to professional medical personnel to provide routine health care, to administer prescribed medications, order x-rays, routine tests, treatment, to release any records necessary, and to arrange or provide medical transportation for my child/myself/my family member. If an emergency arises and the parent or guardian can't be reached, I hereby give my permission to the physician selected by the Club Ministry Leader to secure and render treatment, including hospitalization. I will be financially responsible for all costs incurred thereby, regardless of insurance coverage.

_____ _____

Signature of Parent or Guardian **Date**