AUTHORIZATION FOR MEDICAL TREATMENT

Effective through ______________________

We (I), the undersigned, parent(s)/guardian(s) of ________________________________, a minor, do herby authorize the Church of God (supervisor) or their authorized agent to consent to any X-ray, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed to practice his profession, whether such diagnosis or treatment is rendered at the office of such physicians, any hospital, or other location.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor or his authorized designee in the exercise of their best judgment, upon advice of any such physician and surgeon, may deem advisable.

PLEASE PRINT ALL INFORMATION

Parent/Guardian ____

Address ____

City ______________________________________ State _______________ Zip _______

Home phone (   )_________________________ Cell phone (   )__________________

Medical health insurance company ____

Insurance policy number ____

Minor's date of birth ____

In case of emergency, notify ____

Emergency phone number ____

Relationship to Minor ____

Signature of Parent/Guardian___________________________________ Date________

Signature of Notary Public______________________________________ Date________