Federated Church
2400 Sycamore Lane
West Lafayette, IN 47906
(765) 463-5564

PERMISSION TO ATTEND and AUTHORIZATION TO TREAT A MINOR

Name of Minor: ___________________________________ Date of Birth: _____________

The undersigned authorize the staff or adult leaders of Federated Church as an agent for the undersigned to consent to any X-ray examination, anesthetic, medical, dental, or surgical diagnoses or treatment and hospital care for the above minor which is needed and provided under the general and special supervision of any licensed physician or dentist, at a hospital, camp or elsewhere. The undersigned assumes complete financial responsibility for any and all care rendered under this authorization.

<Please initial the appropriate sections below>

___YES ___NO The undersigned authorizes the staff and adult leaders of Federated Church to administer First Aid as needed in the absence of a physician. These leaders may administer aspirin, Tylenol, or other over-the counter medications, as directed (circle those allowed, specify other or exceptions).

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___YES ___NO The undersigned authorizes the staff and adult leaders of Federated Church to transport the above minor to activities in and around the Greater Lafayette area: (Staff and adult leaders will utilize church-owned or personal vehicles).

___YES ___NO The above minor is allowed to participate in all activities except: (specify exceptions, or write “none” if no exceptions).

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___YES ___NO The above minor is allowed to transport him/herself to special activities in and around the Greater Lafayette area: (family members ONLY may ride in the same vehicle. Otherwise, no passengers are allowed”).

___YES ___NO The above minor is allowed to leave group activities (such as weekly Sunday programs, special lock-ins or activities in and around the Greater Lafayette area) prior to their scheduled completion without parental or guardian notification.

This authorization remains in effect from November 1, 2009 until June 30, 2010.

______________________________ ______________________________
(signature of parent/guardian) *(relationship to Minor)*

(over)

Parent/Guardian

Name(s): ______________________________ ________________________________

Address(es): ______________________________ ________________________________

Phone #s: (home) ______________________________ ________________________________

(cell) ______________________________ ________________________________

(work) ______________________________ ________________________________

Health Insurance Company ____

Health Insurance Policy # ____

Physician ____

Blood Type ________ Date of last Tetanus _________________________

Emergency Contact
Name: ______________________________ Phone(s): ____________________________

Allergies, medications or other health-related information:

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