PARENT/GUARDIAN'S AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR AND INDEMNIFICATION AGREEMENT

I ______________________________________, am the custodial parent having legal custody of ___________________________________, a minor child, age ________, born _______________ I authorize __________________________________an adult sponsor (hereinafter, Sponsor) in whose care I have entrusted my child to do any acts which may be necessary or proper to provide for the emergency health care of the miner child, including, but not limited to the power

(i) To provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such emergency health care, and

(ii) To consent to and authorize any emergency health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentist, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

(iii) To give my child Tylenol/Advil/Ibuprofen, cough syrup, or Pepto-Bismol if needed.
_____Yes _____No

This consent shall be effective throughout my child's attendance and participation in the Convention, including activities preliminary and subsequent thereto.

In consideration of my child being able to attend and participate in convention, I do hereby agree to hold The church/ The Church Christian Academy, Convention, staff, employees, volunteers, helpers, and or agents harmless from any and all present and future liability, actions, causes of actions, claims, expenses, and damages on account of injury, including death to my child or property, which is not the result of gross negligence, intentional neglect, or willful or wanton conduct by the Convention/The Church/The Church Christian Academy, staff, employees, volunteers, helpers, and or agents in connection with medical treatment deemed necessary and authorized by the terms of this Medical Consent Form.

Current Medical Conditions:
(Include nature of any required attention, medications, or other treatment and/or allergies to medication.)

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____

Date of Last Tetanus Booster: ____

Name of Physician: ____________________________________ Phone # __________________

Medical Insurance Information: ____
(company)

Policy # ____

Emergency Telephone Number: ____

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agents named herein. I further state that I HAVE CAREFULLY READ THE FOREGOING INDEMNIFICATION AGREEMENT AND KNOW THE CONTENTS THEREOF AND I SIGN HEREUNDER AS MY OWN FREE ACT.

Date: _________________________

____
Custodial Parent/Guardian - Signature

____
Custodial Parent/Guardian – Printed Name

____
Address

____
City, State, Zip code

____
Telephone Number

____
Name of School

____
School Customer Number

____
School Phone Number

____
Sponsor