

**EASTRIDGE PRESBYTERIAN CHURCH  
1135 EASTRIDGE DRIVE  
LINCOLN, NE 68510-5096**

**AUTHORIZATION AND CONSENT TO TREAT A MINOR**

NAME OF MINOR \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PARENT(S) WORK PHONE \_\_\_\_\_

THE UNDERSIGNED DOES HEREBY GIVE PERMISSION FOR MY (OUR) CHILD, \_\_\_\_\_, TO ATTEND AND PARTICIPATE IN ACTIVITIES SPONSORED BY EASTRIDGE PRESBYTERIAN CHURCH FROM SEPTEMBER 1, 2009 TO SEPTEMBER 1, 2010.

I (WE) AUTHORIZE DESIGNATED YOUTH SPONSORS, IN WHOSE CARE THE MINOR HAS BEEN ENTRUSTED, TO CONSENT TO ANY X-RAY EXAMINATION, ANESTHETIC, MEDICAL SURGICAL, OR DENTAL DISGNOSIS OR TREATMENT, AND HOSPITAL CARE, TO BE RENDERED TO THE MINOR UNDER THE PROVISIONS OF THE MEDICAL PRACTICE ACT BY THE MEDICAL STAFF OF A LICENSED HOSPITAL, WHETHER SUCH DISGNOSIS OR TREATMENT IS RENDERED AT THE OFFICE OF SAID PHYSICIAN OR AT SAID HOSPITAL.

THE UNDERSIGNED ALSO AUTHORIZES DESIGNATED YOUTH SPONTORS TO ADMINISTER FIRST AID TREATMENT DEEMED NECESSARY IN THE ABSENCE OF A PHYSICIAN. THE UNDERSIGNED ALSO AUTHORIZES DESIGNATED YOUTH SPONSORS TO ADMINISTER TYLENOL AND/OR OTHER OVER THE COUNTER DRUGS TO THE ABOVE MINORS AS APPROPRIATE EXCEPT \_\_\_\_\_. (LIST OR INDICATE NONE).

THE UNDERSIGNED SHALL BE LIABLE AND AGREE(S) TO PAY ALL COSTS AND EXPENSES INCURRED IN CONNECTION WITH SUCH MEDICAL AND DENTAL SERVICES RENDERED TO THE AFOREMENTIONED CHILD PURSUANT TO THIS AUTHORIZATION. SHOULD IT BE NECESSARY FOR MY (OUR) CHILD TO RETURN HOME DUE TO MEDICAL REASONS OR OTHERWISE, THE UNDERSIGNED SHALL ASSUME ALL TRANSPORTATION COSTS.

THE UNDERSIGNED DOES ALSO HEREBY GIVE PERMISSION FOR MY (OUR) CHILD TO RIDE IN ANY VEHICLE DESIGNATED BY YOUTH SPONSORS IN WHOSE CARE THE MINOR HAS BEEN ENTRUSTED WHILE ATTENDING AND PARTICIPATING IN ACTIVITIES SPONSORED BY EASTRIDGE PRESBYTERIAN CHURCH.

DATE LAST TETANUS SHOT \_\_\_\_\_ ALLERGIES \_\_\_\_\_

MEDICATIONS CURRENTLY USED \_\_\_\_\_

MOTHER OR GUARDIAN \_\_\_\_\_ FATHER OR GUARDIAN \_\_\_\_\_

**FAMILY PHYSICIAN**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ POLICY/MEMBER # \_\_\_\_\_

**IN CASE OF EMERGENCY, AND PARENT(S) CANNOT BE REACHED, CONTACT:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

PARENT(S)/GUARDIAN(S) SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_