Campus View church of Christ
Parent Consent/Medical Treatment Form

I, the undersigned parent or guardian of _____, a minor, do hereby authorize adult workers with Campus View church of Christ to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Further, as parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.

Insurance Company or Group:_____

Policy Number:_____

(Attach copy of insurance card)

Contact Info *(please print)*

Name of Participant:_____

Parent or Guardian:_____

Address:_____

City:_____ State:_____Zip:_____

Daytime/work phone:_____

Home/parent guardian cell #'s:_____

Signature of Parent or Guardian:_____

My signature confirms that I hereby give witness to the proper completion of this form by the minor's parent or guardian

Signature of Witness:_____

NOTE: Please complete the Medical History on page 2 of this form

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Medical History
Please complete the following information:

Known medical issues:
_____
_____
_____
_____
_____

Allergies: *(include all medication and food allergies)*
_____
_____
_____
_____

Medications: *(please list all medication needs of the minor including instructions for dosing)*
_____
_____
_____
_____
_____

Permission to give over-the-counter medications: YES_____NO_____

Comments:
_____
_____
_____
_____
_____
_____