PARENTAL CONSENT/MEDICAL TREATMENT FORM
SPOKANE VALLEY CHURCH OF THE NAZARENE

I, the undersigned parent of the youth listed below, a minor, do hereby authorize adult workers with the youth of the above named church to consent to any examination, x-ray, 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 at 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 youth named above, I do hereby expressly consent that my son/daughter may receive emergency 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 rendering such service.

Name: _____ Age: _____

Address: _____ Phone # _____

_____

MEDICAL INFORMATION

Medical Insurance Provider: _____

Insurance Number: _____

PARENT INFORMATION

Father's Name: _____ Contact # _____

Mother's Name: _____ Contact # _____

Emergency Contact: _____ Contact # _____

List Allergies _____

List Medications _____

Student Signature: _____

Parent Signature: _____