

PARENTAL CONSENT/MEDICAL TREATMENT FORM
Spokane Valley Church of the Nazarene

I, the undersigned parent/legal guardian of the child/youth listed below, a minor, do hereby authorize adult workers with the minor 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/legal guardian of the minor named below, 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.

Minor's Name: _____ Age: _____

Mailing Address: _____

Phone: _____ Email Address: _____

MEDICAL INFORMATION

List Allergies and/or Medical Conditions: _____

List Medications _____

Medical Insurance Provider: _____

Insurance Number: _____

PARENT INFORMATION

Legal Guardian #1 _____ Contact # _____

Legal Guardian #2 _____ Contact # _____

Emergency Contact: _____ Contact # _____

Legal Guardian Signature: _____

Date: _____