AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I, _____, am the [parent/guardian/managing conservator] of _____, a minor child, and have the power to consent to medical treatment for him/her. [**Include if applicable:** _____ is/are the minor]=s other parent/parents.] I authorize and appoint _____ as my agent to consent to medical treatment of the minor when I cannot be contacted to so consent, such medical treatment to include, without limitation, X-ray examination; anesthetic treatment; medical, dental, or surgical examination or treatment; and general hospital care. No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

I will indemnify and hold harmless from any expense or claim of any nature any entity that provides or causes to be provided examination, treatment, or hospital care under this authorization (except to the extent such entity is negligent therein) and conditionally agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or hospital care.

SIGNED on _____, 20____.

_____
Signature

_____
Printed Name of parent/guardian/managing conservator

Childs name: _____ Birth date: _____

THE STATE OF TEXAS '
'
COUNTY OF DENTON '

BEFORE ME, the undersigned Notary Public, on this day personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he/she executed the same for the purposes and considerations therein expressed and in the capacity therein stated.

WITNESS MY HAND and official seal this _____ day of _____, 20___.

_____
Notary Public, State of Texas

MEDICAL INFORMATION FORM

Name _____ Home Phone _____

Parent/Guardian Name _____ Work Phone _____ Cell Phone _____

Insurance Company _____ Policy Number _____

Family Physician _____ Office Number _____

Name of person (other than self) authorized to act for participant in an emergency:

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Allergies (including drugs): _____

Last Tetanus Shot: _____

Please list any medications to be taken by participant and frequency:

_____

_____

Special instructions or information:

_____

_____

I request that in my absence the above-named student be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, and operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named student.

I release Denton Bible Church, its staff and volunteers from claim or liability due to sickness or injury. I attest to the fact that the above named participant is covered by an insurance policy covering illness and injury. I accept all financial responsibilities concerning any medical emergency.

PARENT/GUARDIAN SIGNATURE

_____ Date _____

_____

(Printed)