

(Description of Event)

Student's Name _____

Birth Date _____

School _____

Grade _____ Age _____

Address _____

Insurance Info.
Co. _____
Policy # _____

Authorization of Consent to Treatment of Minor:

(I) (We), the undersigned, parent(s) of _____, a minor, do hereby authorize Cane Creek
(Student's Name)

Baptist Church youth ministry leaders, as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any physician and surgeon licensed under the provision of the Medical Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

Release of Cane Creek Baptist Church: _____ shall indemnify, hold free and harmless,
(Parent's Name)

assume liability for, and defend Cane Creek Baptist Church, its agents, servants, employees, officers, and directors from any and all costs and expenses including but not limited to, attorney's fees, reasonable investigative and discovery costs, court costs, and all other sums which Cane Creek Baptist Church, assertion of liability, or any claim or action founded thereon, arising or alleged to have arisen out of _____ use of real or personal property belonging to Cane Creek Baptist Church, its'
(Student's Name)

agents, servants, employees, officers, and directors, or by action of omission by _____.
(Student's Name)

Parent _____ (signature) Date: _____

Parent _____ (signature) Date: _____

Home Phone _____ Work Phone _____ Ext. _____

Mobile Phone _____ Pager Number _____

Other Emergency Contact _____ Phone _____

* As an additional assurance of treatment, please have this form notarized below. It is not necessary, but it would be helpful.

_____	_____
County	Expires

Notary	
(Please indicate any special medical information on the back of this form.)	