

Christ's Hope Ministries & Church
2013 Student Ministries
Medical Release Treatment Form

Being the parent or legal guardian of _____, (minor's printed name)

I _____ (parent/guardian's printed name) do consent to any x-ray, anesthetic, medical, surgical or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian, I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical or hospital care or treatment that is given to my child. Any policy of the church or organization sponsoring this event will be used as the secondary coverage.

I understand that responsible representatives (Staff, Volunteers and Parents) of CHMC will have access to this form.

Student Information:

Full Name _____ Age _____ Birth Date _____

Grade _____ Height _____ Weight _____ Social Security Number _____ (optional)

Address _____ City _____ State _____ Zip _____

Phone _____ Parent's Cell _____

Emergency Contact _____ Phone _____ Relationship _____

Medical Insurance Company _____ Policy # _____

Primary Insured's Name _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Current Medications _____

Known Allergies _____

Parent/Guardian Signature: _____ Date: _____