

CORNERSTONE CHURCH MEDICAL TREATMENT AUTHORIZATION FORM

Minor Full Legal Name: _____

Date of Birth: _____ Gender: Female _____ Male _____

Home Address: _____

Parent/ Guardian Name: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____

Alternate Contact in Case of Emergency: _____ Phone Number: _____

Emergency Contact Relationship to Minor: _____

Information for Medical Treatment

Physician's Name and Location of Practice: _____

Physician's Phone Number: _____

Medical Insurer/Health Plan: _____ Policy #: _____

I, the undersigned parent or legal guardian of the child named above, do hereby grant my permission and consent for the said child to attend and participate in the events and activities of Cornerstone Church, both on and off church grounds, including the necessary transportation to and from these events and activities.

Permission is granted for my child to receive medical care if: (1) such care is deemed necessary by the persons in charge of the event; (2) the proposed medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain my parental consent would reasonably jeopardize the life, health, or well-being of the child affected; (3) I cannot be personally contacted.

I further agree not to hold Cornerstone Church of Clarion or any of its paid staff or volunteers responsible for any accident that may occur on the way to, from, or during an event. I indemnify, defend and hold harmless Cornerstone Church of Clarion for all claims made and liabilities assessed against them as a result of any event or activity. I release Cornerstone Church of Clarion and all medical providers from liability in acting on my behalf in this regard and rendering such medical treatment. I assume the risk and financial responsibility for any injury resulting from any event or activity.

Furthermore, I understand and assume the expenses of any property damage caused by my child. Should it be necessary that my child be returned home due to disciplinary action (when on trips), I will be contacted by the leaders and will be responsible to pick my child up and assume the cost of transportation.

I give Cornerstone Church permission to publish in print, electronic, video, or any other format (including website and all media) the likeness or image (picture) of my property, myself or my child including my/ his/her name if Cornerstone Church chooses. I release all claims against Cornerstone Church with respect to copyright ownership and publication including any claim for compensation related to the use of these materials.

This authorization is effective through the following dates: July 24 2023- July 27 2023

Parent / Legal Guardian Printed Name: _____

Parent / Legal Guardian Signature: _____ Date: _____

Medical History

Name: _____ Height: _____ Weight: _____ Date: ____/____/____

Health History

____ Diabetes ____ Emotional/Behavioral Concerns: _____
____ Asthma ____ Serious Illnesses: _____
____ Seizure Disorder ____ Serious Injuries: _____
____ Heart problems ____ Operations: _____

Please list any other medical issues not listed that would be pertinent to your child's care:

Allergies

____ No
____ Yes (Please specify if related to medications, bees, latex, foods, etc. Please list allergies & reactions.)

Permission to Administer the Following

____ Tylenol ____ Ibuprofen ____ Tums/Roloids ____ Pepto-Bismol
____ Benadryl ____ Hydrocortisone Cream ____ Calamine Lotion ____ Antibiotic Ointment

Please do NOT give my child the following.

Current Medications and Dosages

(Medications may only be administered if in the original prescription bottle)

*Please bring inhalers and Epi Pens

Treatment for Tick Bite: Please list how you would like a tick bite handled.

____ Remove tick in first 24 hours and monitor ____ Parent Contact
____ Parent contact & take child to Urgent Care for treatment
____ Other: _____

Parent Signature: _____

If Used for Camps: For Camp Nurse Use Only

Date/Time	Complaint/Symptom	Medication Given	Comments