



# Authorization to Consent to Medical Treatment

2011/2012

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ M / F (circle one)

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Mother's Phone (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Other) \_\_\_\_\_

Father's Phone (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Other) \_\_\_\_\_

## HEALTH INFORMATION

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Address: \_\_\_\_\_ Current Immunizations? Y / N

**LIST:** Chronic illness or allergies \_\_\_\_\_

Current medication \_\_\_\_\_

Any other medical conditions \_\_\_\_\_

**EMERGENCY CONTACTS:** Start your list with the person you want contacted first in case of an emergency and a parent can not be reached. We will continue until one of your contacts has been notified:

1. **NAME:** \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

2. **NAME:** \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

3. **NAME:** \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

I, the undersigned parent/guardian of \_\_\_\_\_, do hereby authorize Lifegate Christian Mid/High School Administrative/Staff member 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 rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital and to transport by an emergency vehicle to said facility should it be necessary.

I, the undersigned, will be financially responsible and promise to make payment for all services consented by Agent(s) that are not covered by my personal medical insurance. Agent(s) shall NOT have the authority to withdraw or withhold any life support health care, treatment, procedures or equipment.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date