PLYMOUTH HEIGHTS CHRISTIAN REFORMED CHURCH
Parental Consent for Medical Treatment of Minor

____________________________________ ____________________________________

Name of Parent or Guardian (please print) Name of Minor (please print)

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Name of Parent or Guardian (please print)

The parent(s) or guardian(s) listed above has temporarily entrusted the minor to the care of Plymouth Heights Christian Reformed Church and its adult supervisors and staff members. If, after reasonable attempts are made to contact the parent(s) or guardian(s), the parent(s) or guardian(s) are unavailable:

The parent(s) or guardian(s) authorizes Plymouth Heights Christian Reformed Church and the adult supervisors and staff members to consent to any x-ray examinations, anesthetic, medical and/or surgical diagnosis and/or treatment, hospital care, and/or dental care for the minor which is recommended by a licensed medical care provider and which will be performed by a licensed medical care provider, licensed within the state or country where the services are to be performed. **Special medical care information for the minor is on the reverse side of this form.**

The parent(s) or guardian(s) understands that this authorization is given before any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and/or hospital care is required, but is given to provide authority and power to Plymouth Heights Christian Reformed Church and its adult supervisors and staff members to give specific consent for medical or dental treatment or hospital care when advised by a licensed medical care provider and when the minor's parents are unavailable to give consent.

The parent(s) or guardian(s) authorizes any hospital which has provided treatment to the minor to return physical custody of the minor to Plymouth Heights Christian Reformed Church and its adult supervisors and staff members when treatment is completed.

The parent(s) or guardian(s) agrees to fully pay for any and all costs of medical or dental care provided to the minor and consented to by Plymouth Heights Christian Reformed Church and/or its adult supervisors and staff members. **Medical Insurance Information is on the reverse side of this form.**

THIS AUTHORIZATION SHALL REMAIN EFFECTIVE UNTIL REVOKED IN WRITING AND DELIVERED TO PLYMOUTH HEIGHTS CHRISTIAN REFORMED CHURCH.

Dated: ______________________ ____________________________________

(parent or guardian signature)

Dated: ______________________ ____________________________________

(parent or guardian signature)

Please fill out both sides and return to:
Plymouth Heights Christian Reformed Church
1800 Plymouth, S.E.
Grand Rapids, MI 49506
(616) 243-5638

(Please complete back side of form)

MEDICAL INFORMATION

Name of Minor: ________________________________

Emergency Phone Numbers: _________________ home

_________________ work

_________________ cell

Date of Birth: _____/_____/_____

Name of Parent(s) or Guardian(s): ____

Address: ____

Doctor's Name: ____

Doctor's Telephone: ____

Doctor's Address: ____

SPECIAL MEDICAL CONDITIONS OF MINOR

Allergies/treatment: ____

Medications (including name, purpose, dosage): _________________________________

____

Other conditions/precautions: ____

____

INSURANCE INFORMATION

Insurance Company: ____

Policy Number: _____________________ Plan Number: _________________________

Claim Office Telephone Number: ____

Claim Office Address: ____

Employer Name and Address: ____

Employer Telephone Number: ____