

Authorization For Consent To Treatment Of Minors

Full name of minor: _____ Date of Birth: MM/DD/YY

Name of person responsible for this minor during camp week: _____

Where will this person responsible for the above minor be staying? _____

Phone: () _____

Please list the allergies your child may have (e.g. medications, foods, insect bites):

Please list any medication your child is presently taking and for what reason.

Medication

Reason

_____	_____
_____	_____
_____	_____

Does your child have a medical history of the following?

Asthma:

Hypoglycemia:

Hay Fever:

Bleeder:

Epilepsy:

Migraines:

Heart Problems:

Anxiety Disorder:

Diabetes: Taking Insulin? Y N

Dosage: _____

Date of last Tetanus shot: MM/DD/YY

Name of child's Doctor: _____

Phone: () _____

Is this minor covered by medical insurance? Y N

Name of medical insurance company: _____

Policy Number: _____

(Please attach a copy, both front and back, of your insurance card)

I, _____

Phone: () _____

of _____

(street address, City, State, Zip)

hereby state that I am the Parent, or Legal Guardian of the above named child and that I authorize any necessary emergency medical treatment for the above named child while participating and being cared for by the Believers' Christian Fellowship Ohio Family Convention at 1695 Stewart Road, Lima, OH 45804, (419) 221-0085, for the duration of the convention (July 10-13, 2008).

Signature of Parent or Guardian: _____

Date: _____