



# Authorization for Medical Treatment

First Alliance Church  
20444 Midway Blvd., Port Charlotte, FL 33952, (941)625-7435

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Year of Graduation \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip

Phone Number \_\_\_\_\_ Emergency Contact Number \_\_\_\_\_

### Authorization of Consent to Treatment of Minor:

This authorization shall remain effective through the above named minor's graduation from high school, unless sooner revoked in writing delivered to said agent(s).

(We), the undersigned parent(s)/guardian(s) of \_\_\_\_\_ a minor, do hereby authorize First Alliance Church youth ministry leaders as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered under the general or special supervision and upon the advise of a physician. We further agree to hold First Alliance Church, its agents or employees harmless for any medical treatment administered on the basis of this consent.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. We agree to hold the physician(s) and First Alliance Church harmless for any treatment so provided.

Parent / Legal Guardian

\_\_\_\_\_  
Signature

Home Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Parent / Legal Guardian

\_\_\_\_\_  
Signature

Home Phone: ( ) \_\_\_\_\_

Cell: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Other Emergency Contact \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Family Doctor \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Insurance Co. \_\_\_\_\_

If none please check \_\_\_\_\_

Insurance Policy # \_\_\_\_\_

Group # \_\_\_\_\_

Known Medical Conditions /Allergies \_\_\_\_\_

Last Tetanus Immunization \_\_\_\_\_

Contact Lenses? Y / N

Will you allow blood transfusions? \_\_\_\_\_ Other \_\_\_\_\_

### CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

This document was acknowledged before me on \_\_\_\_\_ [date] by

\_\_\_\_\_ [name of principal].

[Notary Seal, if any]:

\_\_\_\_\_  
(Signature of Notarial Officer)

Notary Public for the State of \_\_\_\_\_

My commission expires: \_\_\_\_\_