

**CONSENT FOR TREATMENT OF A MINOR**

NAME: \_\_\_\_\_ M/F: \_\_\_\_\_

LAST FIRST

ADDRESS: \_\_\_\_\_

STREET

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_

ROOMATE REQUESTS: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**OTHER EMERGENCY CONTACTS:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parents Employers: \_\_\_\_\_ Address: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy #: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

1. To your knowledge, has your child been exposed to any communicable diseases within the past 21 days? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

2. Do you know of any health factor(s) that make it advisable for your child to follow a limited program of physical activity? Yes \_\_\_ No \_\_\_

If yes, please explain: \_\_\_\_\_

School Attending: \_\_\_\_\_ Church Attending: \_\_\_\_\_

**HEALTH HISTORY:** To protect your child from possible embarrassment, but not to exclude him/her from the program, please list any health concerns that we should be aware of. Also include any known allergies to drugs/and or insect stings.

A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_

Frequent Ear Infections \_\_\_\_\_ Heart Defect/Disease \_\_\_\_\_ Convulsions \_\_\_\_\_ Diabetes \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_

Bleeding/Clotting Disorder \_\_\_\_\_ Sleep Walking \_\_\_\_\_ Night-Time Incontinence \_\_\_\_\_ Operations/Serious Injuries \_\_\_\_\_

Chicken Pox \_\_\_\_\_ German Measles \_\_\_\_\_ Date of Child's last tetanus shot: \_\_\_\_\_

Name and Phone Number of your Child's regular physician: Dr. \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**PLEASE LIST ANY MEDICATION THAT YOUR CHILD WILL NEED TO HAVE WHILE AT CAMP:**

MEDICATION:	DOSAGE:	WHEN TAKEN:
_____	_____	_____
_____	_____	_____

\*\*In the event of a minor illness or injury (such as cold, headache, scrapes, sprains, abrasions, and/or small cuts), I do authorize the Youth Pastor, R.N. or EMT to give my child common remedies such as Tylenol, cough medicine, etc., in dosages appropriate for his/her age, and to clean and bandage or wrap wounds as necessary.

**IMPORTANT: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN**

The health history is correct to the best of my knowledge, and the person herein described has permission to engage in all prescribed camp activities unless noted by me and/or my physician. I hereby give permission to the physician selected by the Youth Pastor (or his/her representative) to order X-rays, routine tests, and treatment for the health of my child and to order injections and or anesthesia and/or surgery for my child named above. This authorization is given pursuant to Section 25.8 of the Civil Code of California. This authorization shall remain effective through the extent of the scheduled program with Calvary Chapel Costa Mesa and Calvary Chapel Chino Valley unless sooner revoked in writing and delivered to said agent. I further agree that Calvary Chapel Costa Mesa, Calvary Chapel Chino Valley, their Boards of Directors and staff are hereby relieved of all liability in the event of an accident or injury to said Minor.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Minor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work/Emergency Phone: ( ) \_\_\_\_\_