

# PARENTAL CONSENT



# MEDICAL RELEASE

# WEST SIDE STUDENT MINISTRY



**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone #** \_\_\_\_\_ / \_\_\_\_\_

**Person To Notify** \_\_\_\_\_ **#** \_\_\_\_\_

The undersigned parent or guardian of \_\_\_\_\_, a minor, do hereby consent to any emergency X-ray, anesthetic medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general special supervision of any physician and surgeon licensed under the provision of the Medical Practice Act.

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; and neither said agent or any organization involved assumes any financial responsibility for exercising this action. I understand and do hereby give my consent to the above stated conditions.

**Parent/Guardian Signature** \_\_\_\_\_ **Date:** January 1, 2012 ~ December 31, 2012



## ***PERSONAL INFORMATION:***

Student's Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Grade \_\_\_\_\_ Sex: [ ] F [ ] M

Known Allergies \_\_\_\_\_

Special Medication \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Physician \_\_\_\_\_

Dentist \_\_\_\_\_

Orthodontist \_\_\_\_\_

Insurance Policy Name \_\_\_\_\_

Insurance Policy Number \_\_\_\_\_

Other Relevant Information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emergency Phone Numbers:

Father @ Work \_\_\_\_\_ / \_\_\_\_\_ Mother @ Work \_\_\_\_\_ / \_\_\_\_\_

Friend/Relative \_\_\_\_\_ Phone # \_\_\_\_\_ / \_\_\_\_\_

