

Consent for Medical Treatment Form
Crown of Glory Lutheran Church
1141 Cardinal Street
Chaska, MN
952-448-3230

I, _____ (*Name of Parent/Legal Guardian*), am the **parent or legal guardian** of my **SON/DAUGHTER** _____ (*Name of Youth*). I give permission for my child to attend and participate in the activities of CROWN OF GLORY LUTHERAN'S Youth Ministries. I give permission for my child to ride a *Church Van* or in *Church provided vehicles* for youth related activities. I release Crown of Glory Lutheran Church and its staff from any damages which may result due to accidents or injury.

Further, I, the undersigned, hereby authorize a representative of Crown of Glory Lutheran Church into whose care my child has been entrusted, to consent to, and to authorize any emergency medical care, surgery, and/or dental care for my son/daughter.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on part of the supervisor and his/her authorized designee, to exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and/or surgeon.

Signature of Parent or Legal Guardian: _____

Dated: _____

Please Print Clearly:

Name of Youth: _____			
Name of Parent/s or Legal Guardian: _____			
Address: _____		City: _____	State: _____ Zip: _____
Home Phone: (____) _____		Work Phone: (____) _____	
Cell Phone: (____) _____		Email: _____	
Secondary Address if applicable: _____			
Name and Phone Number of another person to contact in case you cannot be reached:			
Name: _____			
Relation to Youth: _____			
Phone: (____) _____			

Medical Information:

Family Physician: _____
Physician Phone: _____
Family Medical Insurance Company: _____
Policy/Account Number: _____
Please List any Allergies, Medications currently using, Physical limitations, other comments related to your child's health: _____