August 2018

to

August 2019

Crossroads Nazarene Church

PARENTAL AUTHORITY TO CONSENT TO TREATMENT OF MINOR

Student Name: ____

Mother/Guardian Name: ______________________________ E-mail: ____________________________

Phone: ____

Cell Phone Work Number

Father/Guardian Name: ______________________________ E-mail: ____________________________

Phone: ____

Cell Phone Work Number

Emergency Contact Name: _____________________________________

Phone: ____

Cell Phone Work Number

____

Herein "Parent /Guardian" or if over 18

Crossroads Student Ministries

AZ/SO NV N.Y.I. "Organization"

____

Herein "Minor" *(student)*

Pastor Brent Myers or Pastor Alicia Riley

or their duly appointed designee

Youth Pastor/Director/Sponsor Herein "Agent"

I the above named Parent/Guardian of the Minor has entrusted the Minor into the care of the Agent, a duty authorized representative of Crossroads Nazarene Church, while the Minor participates in an activity sponsored by Crossroads Nazarene Church and for the welfare of the Minor. I do hereby grant to the above mentioned Agent, full power and authority to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and/or surgeon licensed under the provisions of the Laws of the State/Country in which the medical care is being sought and on the medical staff of any hospital or to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment to be rendered to the Minor by any dentist licensed under the laws of the State or Country in which the dental care is being sought. It is understood that this authorization is given in advance, but is given to provide authority and power on the part of the Agent to give specific consent to any and all such examinations, anesthetics, diagnosis, treatment, or hospital care which the aforementioned surgeon, physician and/or dentist, in the exercise of his/her best judgment, may deem advisable. This authorization is given pursuant to the provisions of the laws of the State/Country in which the medical or dental care is being sought. The Parent/Guardian hereby authorizes any hospital which has provided treatment to the Minor to the Agent upon the completion of treatment. This authorization is given pursuant to provisions of the laws of the State or Country in which the medical or dental care is being provided. The Parent/Guardian hereby agrees to pay all costs of medical or dental care incurred for the Minor by the Agent, or the Organization, under this authorization. Also, I the undersigned further state that I do hereby grant to the *Agent* full power and authority to control and discipline the aforementioned child/teen, but that such authority shall not extend to or include any form of physical corporal punishment to said child/teen. I expressively waive any and all claims against the Crossroads Nazarene Church and/or any of its Pastors, Boards and its leaders and representatives, because of illness, injury, or damage to the person or property of the aforementioned child/teen in connection with said activity.

This consent is valid and effective August 2018 - August 2019

____

Parent/Guardian Signature (If over 18 please sign yourself)

Sign in presence of Notary.

(this portion completed by notary)

State of: ______________________

County of:______________________

Sworn to me and subscribed in my presence

This _______ day of ___________, 20______

______________________________ _______________

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Crossroads Nazarene Church

Confidential Medical Questionnaire

Student Name: ____
Last Name First Name MI

Date of Birth: ______________ Grade: ______________ Gender: ____________

Address: ____________________________ City/State: ______________ Zip: _________

Medical Insurance Company: ____

Policy #: ____________________________ Group #: ______________________________

Doctor's Name: ____________________________ Phone Number: ______________________

Please answer all of the following questions and give any other pertinent medical information:

Is your student presently under treatment for any medical problems? ______________________

Do they take any medication routinely? Yes / No If yes, list medication and dosage schedule:

____

____

Has your student ever been unconscious, or had any head injuries? (please explain) Yes / No

____

____

Is your student allergic to any medication, certain types of food, or insect bites (bee stings)? Yes / No

____

Have they had, or do they presently have asthma, hay fever, hives, eczema, or seizures? Yes / No

(please explain) ____

Do they have a history of diabetes/heart disease/rheumatic fever? ______________________

Do they require any type of injection (allergy or other) on a regular basis? (please explain) __________

____

Date of Students last tetanus shot: __________ / __________