

**PERMISSION FOR MEDICAL TREATMENT**  
**LONE OAK CHURCH OF CHRIST YOUTH ACTIVITIES**

TO WHOM IT MAY CONCERN: I, the undersigned, being the parent, legal guardian or legal next-of-kin of:

\_\_\_\_\_

(Fill in full name)

hereby authorize any necessary medical treatment for this person while participating in church activities. I also guarantee payment of all charges incurred during the treatment. (Ambulance, physician, hospital, x-rays, lab, drugs, etc.)

In regard to such person, I submit the following information:

1. ALLERGIES TO FOODS, MEDICATION , ETC. (If none, so state; if yes,specify)

\_\_\_\_\_

2. Special medical problems (If none so state, if yes specify):

\_\_\_\_\_

3. If the student now under medical care? If so, describe nature of illness and treatment:

\_\_\_\_\_

4. Does participant carry medication on person? \_\_\_\_\_  
(If none, so state) Name of medication: \_\_\_\_\_

5. Date of last Tetanus: \_\_\_\_\_

6. Family physician/clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Office Address \_\_\_\_\_

SIGNATURE OF PARENT or  
LEGAL GUARDIAN \_\_\_\_\_ Date \_\_\_\_\_

Print or type name of person signing \_\_\_\_\_

Relationship of person signing \_\_\_\_\_

Residence Address \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business/Mother \_\_\_\_\_ Business/Father \_\_\_\_\_

Emergency Name and Numbers if above is not available \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Notary: \_\_\_\_\_

Commission Expires: \_\_\_\_\_