

Emergency Medical Authorization

YOUNG PERSON'S NAME: _____

IN THE EVENT I CANNOT BE REACHED TO MAKE ARRANGEMENTS FOR EMERGENCY MEDICAL CARE, I HEREBY AUTHORIZE STEVEN D. SMITH OR ANY OTHER YOUTH GROUP SPONSOR OF THE FAIRMONT PARK CHURCH OF CHRIST TO GIVE CONSENT FOR ANY NECESSARY EMERGENCY CARE FOR MY CHILD WHEN THE CHILD IS IN THIS INDIVIDUAL'S CARE.

SIGNATURE OF PARENT OF GUARDIAN

DATE

Young Person's Blood Type (if known) _____

Medical Problems _____

Allergies (List Medicines or other things.) _____

PERSONS TO BE CALLED IN CASE OF EMERGENCY:

NAME

PHONE

NAME

PHONE

PERMISSION FOR TRANSPORTATION

The Fairmont Park Church of Christ has my permission to transport my child on planned local trips away from the Fairmont Park facility and on out of town trips (local meaning within the Midland/Odessa area). I understand that all precautions will be taken to ensure the safety and health of my child. In signing this I acknowledge that I will not make the Church, its chaperones or its drivers responsible in the event of an accident.

PARENT'S SIGNATURE

DATE

Permission for Publishing Pictures

I am aware that my child may be photographed or video taped while attending youth ministry activities. I give permission for any photographs or videotapes including my child to be published in Fairmont Park Publications such as **Fairmont Park Family Newsletter**, Fairmont Park Websites, and Video presentations.

Parent's Signature

Date

TO WHOM IT MAY CONCERN:

I hereby give permission to any hospital to render the treatment necessary in case of emergency, for

NAME _____, the son or daughter of _____ from
CITY _____, STATE _____. We, the parents signed below, will be responsible
for payment of medical services provided to the child mentioned above.

Our insurance is with _____.

The policy number is _____.

Signed this _____ day of _____, 2012.

Signed _____
Guardian or parent

Address, City, State, Zip

Phone _____

Emergency Phone _____

Place of Business _____

Business Phone _____

SSN of Parent _____

SSN of Child _____

Birthdate of Child _____

(The above information is what the Hospital will ask for if we need to get them treated.)