

# Wakeshma Community Church RealLife Youth Ministries

## 2009 EMERGENCY MEDICAL AUTHORIZATION

Wakeshma Community Church • 16732 E. UV Ave. • Fulton • MI 49052 • 269-729-5431

This medical form must be signed by a parent or guardian, and be on file for the child or young person who wishes to participate in any activity sponsored by Wakeshma Community Church.

**Student name :**

\_\_\_\_\_  
(last) (first) (middle)  
Residential Parent(s)/Guardian(s)

\_\_\_\_\_  
(name and relationship) (name and relationship)  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Student birth date \_\_\_\_\_

Mother Daytime Phone ( ) \_\_\_\_\_ Cellular/Pager ( ) \_\_\_\_\_

Father Daytime Phone ( ) \_\_\_\_\_ Cellular/Pager ( ) \_\_\_\_\_

**Is there a court order which limits/prohibits non-custodial parent contact?** Yes No

If yes is circled, parent must provide legal documentation

**Neighbor or other person who will care for your child:**

Name	Relationship	Phone
1 _____		

2 _____		
---------	--	--

Allergies: \_\_\_\_\_ Medication(s) being taken: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Physical impairments : \_\_\_\_\_  
(heart, epilepsy, etc.)

Is there any CRITICAL medical information to which the physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**In the event that reasonable attempts to contact me or the persons listed on this card have been unsuccessful I hereby give my consent for:**

1. the administration of any treatment deemed necessary by (preferred physician)

Dr. \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
or (preferred dentist) Dr. \_\_\_\_\_ Phone ( ) \_\_\_\_\_

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

2. the transfer of the child to (preferred hospital) \_\_\_\_\_ or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Parent or Guardian)

Witness \_\_\_\_\_  
(Person other than parent or guardian)

**A facsimile or photocopy of this form shall be as valid as the original.**