Parkers Lake Baptist Church

Medical Release/Consent

2024

Parent Name:____

Name of Minor:____

Cell:______-______-________ **Email:**________________________@_________________**.com**

Secondary Emergency Contact:__________________________ **Cell**:______-______-________

Allergies/Medications:____

____

Insurance Name:____

Insurance Group:___________________ **Insurance Phone Number:** ______-______-________

We (I) authorize an adult from Parkers Lake Baptist Church, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis/treatment and hospital care. This care may be rendered to the minor under general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether a diagnosis/treatment is rendered at the office of said physician or at said hospital. I understand that a reasonable attempt will be made to contact parent/guardian before diagnosis/treatment is administered, based on supplied information. I also understand that this Medical Release is intended to be valid for the calendar year, namely 2024. (If any information contained on this form should change, please notify the church secretary.)

Parent Signature:____ **Date**:______-______**- 2024**

Parkers Lake Baptist Church
14720 County Road 6
Plymouth, MN 55447