St. Philip Presbyterian Church
4807 San Felipe
Houston, TX 77056
713-622-4807

AUTHORIZATION & CONSENT TO TREATMENT OF MINOR

Name of Minor (Please complete one form per child)

First: _____

Last: _____

I give my permission for the child I listed above to participate in all events sponsored by St. Philip Presbyterian Church of Houston, Texas, on or off of the campus.

I AUTHORIZE any adult sponsor or representative of St. Philip Presbyterian Church of Houston to consent to medical treatment of such minor when I cannot be contacted to so consent, such medical treatment to include, without limitation, X-ray examination, anesthetic, medical, dental or surgical examination or treatment and general hospital care. No prior determination of life threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

I SPECIFICALLY CERTIFY AND AGREE THAT: Except as indicated at the end of this paragraph, this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the adult to give specific consent to any and all such examinations, treatment or hospital care. The possession of the original of this Authorization by the adult is evidence that he/she has care and control of such minor and that I cannot be contacted. I am solely responsible for and guarantee all charges incurred as a result of any medical care provided under this Authorization and Consent to Treatment of Minor and agree to make or cause to be made, by assignment of third party benefits or otherwise, full and complete payment for such examination, treatment or hospital care. I am the person having the power to consent to medical treatment of such minor. All blanks of this Authorization were filled in before I signed this Authorization.

Parent/Guardian Name (insured)_____

Parent/Guardian's Employer _____

Insurance Information:

Insurance Company _____

Group # _____ Cert. # or Member # _____

Medical Information:

Pediatrician's Name _____ Phone Number:_____

Last Tetanus Shot _____ Allergies _____

Medical Conditions _____

Medications taken? ☐ No ☐ Yes, please specify:_____

_____	_____	_____
Work Phone	Cell Phone	Home Phone

Parent/Guardian Signature _____ Date_____

(handwritten) For Use Next Year:

This information is correct as of _____ Signature of parent_____