

Fairmont Seventh-day Adventist Church

CONSENT & AUTHORIZATION FORM

June 2017-May 2018

Name of participant _____

Address _____

City _____ State _____ Zip _____

MEDICAL TREATMENT CONSENT & PHOTO USE AUTHORIZATION FORM

I, the undersigned parent or guardian of the minor indicated above, do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event that I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care. Further, as parent or legal guardian I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, hospital care or treatment that is given to my child. Any policy of the church or organization sponsoring this event will be used as the secondary coverage. I release all photos and videos taken for use as Fairmont Seventh-day Adventist Church event promotions, both online and in print. This consent shall remain in continuous effect until revoked in writing or until said minor is removed by the parent or guardian from the care of the church sponsor. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian's Signature _____ Date _____

Phone number(s) in case of emergency _____