AUTHORIZATION FOR MEDICAL TREATMENT

I, _____, am the parent or legal guardian of _____ (hereinafter "my child"), who was born on _____.

My child is attending and participating in activities at the HSRC sports program located at Family of Faith Church, 6645 W. Steger Road, Monee, IL 60449 beginning on _____.

I hereby authorize the director of the program, the coach of the particular sport, and their officers, agents, or employees that are 18 years old or older, who supervise the activities at the HSRC sports program into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advise of or to be rendered by a licensed physician or surgeon for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a licensed dentist for my child.

I further authorize the director of the program, the coach of the particular sport, and their officers, agents, or employees that are 18 years old or older, who supervise the activities at the HSRC sports program to receive custody of my child, upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to the director of the program, the coach of the particular sport, and their officers, agents, or employees that are 18 years old or older who supervise the activities at the HSRC sports program.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the director or coach or his/her authorized designee, in the exercise of his/her best judgment, upon advice of such physician, dentist and surgeon may deem advisable
Dated: _____,2_____.

_____
SIGNATURE OF PARENT OR GUARDIAN

Additional information:

_____

Parent/Guardian

_____

Address

_____

City State Zip Code

_____

Home phone no. Work phone no. Cell phone no.

_____

Medical/Health Insurance Company Insurance Policy No.

_____

In case of emergency, notify Relationship to minor

_____

Emergency phone no.

_____

Allergies/Allergic reactions of my child

_____

Medicine being taken by my child

_____

Other information regarding my child's health that a doctor should know