Trinity United Methodist Church
107 E. Angelica St Rensselaer, IN 47978
219-866-7271

Consent To Treatment Of Minor Child

Child's Full Name _____ Today's Date _____
Age _____ Birth Date: _____ Male _____ Female _____
Allergies _____
Tetanus (Date Of Last Immunization) _____
Medication Taking Now (Name, Dosage, Times Taken)
_____
Family Dr. _____
Recent Illness/Exposures To Communicable diseases
_____
Parent/Guardian's Full Name _____
Address _____
Phone (H) _____ (C) _____
Insurance Co. Name _____
Please Include A Copy Of Both Sides Of The Card
Emergency Contact _____
Phone (H) _____ (C) _____

I HEREBY GIVE MY CONSENT TO HOSPITAL APPOINTED BY YOUTH LEADERS AND PHYSICANS TO ADMINISTER AND PERFORM ALL EMERGENCY TREATMENT WHICH IN THE JUDGEMENT OF SAID PHYSICANS MAY BE CONSIDERED NECESSARY OR ADVISABLE FOR ABOVE STATED CHILD.

_____ _____
Parent/Guardian Signature Date

Witnessed By _____ _____
Notary Public Signature Comm. Exp.