FORM 511.4 MEDICAL AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN OF:

________________ Child's name ________________ Regarding Trip/Event ________________ Dates of Trip/Event

Emergency Medical Treatment Authorization

As Parent/Guardian of ________________ (Name of child), I understand that the Church will provide adult supervision and take reasonable precautions to provide a safe environment for children on field trips. I also recognize that there are risks to travel and the ***Peace Lutheran Church of Galloway*** cannot guarantee my child's safety. If there is an accident or injury that results in a medical emergency affecting my child while on this field trip, I provide medical permission to the ***Peace Lutheran Church of Galloway*** and to the adults supervising the Church activity identified above to authorize emergency medical treatment under the following conditions: 1) if there is an accident or injury that results in need for medical emergency treatment affecting my child, and if Church personnel are unable to reach me, or 2) if there is need for immediate medical emergency treatment and there is insufficient time to attempt to reach me. Under these conditions, I do hereby grant permission to the adults supervising the said Church activity, or to any licensed hospital or physician, to authorize emergency medical treatment for my child. I agree to hold the responsible party who grants such permission harmless for that act and hereby release that individual from any liability in connection with granting permission for treatment.

________________ Parent/Guardian Signature ________ Date ________________ Parent/Guardian Signature ________ Date

Special Medical Needs Information

As Parent/Guardian of ________________ (Name of Child), I also specifically inform the ***Peace Lutheran Church of Galloway*** and the responsible adults participating in the said trip/event that my child has the following special needs:

My child has the following medical needs:

____
List medical problems or conditions, allergies, etc.
____

My child needs the following medications:

____
List medications prescriptions
____

My child requires the following special diet:

____
____

Name and telephone number of health insurance company, if any:

____

________________ Parent/Guardian Signature ________ Date ________________ Parent/Guardian Signature ________ Date