Central Student Ministries Medical Permission Slip

I, the parent/guardian of

____

(Youth's full name)

Do hereby consent to any x-ray examination, anesthetic, medical/surgical diagnosis or treatment, or hospital services that may be rendered under the general or specific instructions of any licensed physician selected by the Central Student Ministries leaders throughout the **2016 year**. This includes trips, retreats, or any other activity sponsored by Central Student Ministries.

I certify that I have legal right to authorize proper treatment. I also understand that in the event medical treatment is required, every effort will be made to contact me.

Parent/guardian ____
Telephone (___)______________ EMERGENCY # ______________
Address ____
Birthdate of Youth ______________

Insurance Company ____
Policy Number ____
Agent ____________________________ Phone _________________

Date of last tetanus _______________
Allergies to medication ______________________________________

Please include any specific comments regarding your child's condition (allergies, regular medication, physical problems, etc.) Also make note of any recurring conditions to be aware of (asthma, diabetes, heart condition, or other problem).

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Signature of Parent or Guardian _________________________