TRAVEL CONSENT AND AUTHORIZATION TO TREAT A MINOR

TO: Any Physician, Hospital or Other Health Care Provider:

RE: _____EVENT & DATE: _____
Name of Minor

I hereby give my consent for the above-named student to participate in the above-named event of First Presbyterian Church, Ada, OK and to ride in a vehicle with Sponsors or other representatives of the church, or any parent, on the above-named church-sponsored youth trip.

It is understood that even though all precautions to ensure the student's safety will be taken, the possibility of an accident still remains. I understand that First Presbyterian Church, Ada, OK is not responsible for any accidents that may occur. In case of an accident, I, the parent (guardian) of the above-named student, a minor, do hereby authorize a representative of First Presbyterian Church, Ada, OK as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision, of any physician and surgeon licensed under the provisions of the Medical Practice Act or the medical staff or any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital; and/or x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered by a licensed dentist.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable. Upon the completion of treatment, authorization is given to surrender physical custody of such minor to the above-named agent(s).

NOTE: A photocopy of this form shall be considered as valid as the original.

This authorization shall remain in effect until _____ (one day after event).

Parent Signature: _____ Date: _____

Doctor's Name: _____ _____ Phone:_____

Restrictions/Medications/Allergies:_____

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