*Name*___________________________________

# Fishers of Men Lutheran Student Ministries
## AUTHORIZATION TO CONSENT TO THE TREATMENT OF A MINOR

I/We, the undersigned, parent(s) or legal guardian(s) of _________________________ a minor, do hereby authorize Fishers of Men Lutheran Church as agent for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care of service, which is deemed advisable and is to be rendered to said minor, under the general or specific supervision of any physician and surgeon licensed, or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis or treatment or hospital care being required, but is given to provide authority and power on the part of our afore said agent as specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician/surgeon in the exercise of his/her best judgment may deem advisable to protect the life and health of said minor child.

I/We hereby authorize any hospital, which has provided treatment to the above named minor to surrender physical custody of said minor to the above named agent upon completion of treatment.

**This authorization shall remain effective for as long the minor is involved with Fishers of Men Lutheran Student Ministries unless sooner revoked in writing and delivered to said agent.**

Father's Signature ____________________________ Work Phone____________________
(Please print) ____________________________ Mobile Phone___________________

Mother's Signature_____________________________Work Phone____________________
(Please print) _____________________________ Mobile Phone___________________

Address_______________________________________________________________________

City_______________________________________ State_______________Zip__________

Today's Date_______________________________

**Please attach a copy of the front and back your insurance ID card here.**

# MEDICAL INFORMATION – PLEASE PRINT OR TYPE

**Name:**_______________________________________________________**HomePhone:**________________
(LAST) (FIRST) (MIDDLE)

**Date of Birth:** _____/_____/_____ **Age:** _____ **Sex:** _____ **Male** _____**Female**

**GENERAL HEALTH INFORMATION** *(TO BE READ AND COMPLETED BY PARENT/ LEGAL GUARDIAN)*
Does student have – (if *"yes"* explain)
____ yes _____no ALLERGIES________________________________________________________________________

_____yes _____no HEART CONDITION__________________________________________________________________

_____yes _____no ASTHMA___________________________________________________________________________

_____yes _____no OTHER____________________________________________________________________________

Is student subject to – (if *"yes"* explain)
_____yes _____no FAINTING_________________________________________________________________________

_____yes _____no SLEEP WALKING____________________________________________________________________

_____yes _____no UPSET STOMACH____________________________________________________________________

_____yes _____no OTHER____________________________________________________________________________

Does student have reaction to – (if *"yes"* explain)
_____yes _____no BEE STING________________________________________________________________________

_____yes _____no PENICILLIN_______________________________________________________________________

_____yes _____no OTHER DRUGS______________________________________________________________________

_____yes _____no POISON IVY, OAK, SUMAC___________________________________________________________

_____yes _____no OTHER____________________________________________________________________________

Please indicate anything else which leaders should know to help avoid or deal with any situation that might arise_________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Date of last Tetanus Shot: _____/ _____/ _____

Please list any medications the student is currently taking, over the counter or prescription___________________________________

______________________________________________________________________________________________

**EMERGENCY MEDICAL INFORMATION**

Name of Relative/Friend_____________________________________________________Phone Number _______________________

Name of Relative/Friend_____________________________________________________Phone Number _______________________

Name of Doctor____________________________________________________________Phone Number_______________________

Insurance Company_________________________________________________________Phone Number_______________________

**EMERGENCY PROCEDURE: IN** THE EVENT OF AN EMERGENCY, LEADERS WILL ATTEMPT FIRST TO CONTACT THE PARENT AND/OR DOCTOR. IN THE EVENT THAT IT IS IMPOSSIBLE TO DO SO, PLEASE NOTE THE FOLLOWING:

_____yes _____no 1. With my signature, I hereby authorize First Aid by Fishers of Men Lutheran Student Ministry agents.
_____yes _____no 2. With my signature, I hereby authorize emergency medical care by hospital staff and/or doctor selected by Fishers of Men Lutheran Student Ministry agents.
_____yes _____no 3. With my signature, I authorize physicians selected by Fishers of Men Student Ministry agents to Hospitalization, secure proper treatment for, and to order injections, anesthesia or surgery.
_____yes _____no 4. IF answers to either #1, #2, or #3 is *"NO", YOU MUST* indicate below the procedures to be followed in the event that we are not able to contact you.