Montana Conference of Seventh-day Adventists

Medical Consent

Club Ministries (Adventurers/Pathfinders)

Guardian and Emergency Contact Information

This form must be filled out at the beginning of every year to cover the activities for the year.
A copy of each child's form must be taken on off-site activities.

Child's name _____Age _____ DOB _____

Gender _____

Address_____

Father/Guardian _____ Work # _____

Cell# _____

Mother/Guardian _____ Work # _____

Cell#_____

Emergency Contact _____ Work # _____

Cell#_____

Attendee's Health Record & Medical Information

Child's Physician's Name _____

Phone:_____

Insurance Carrier _____

Member #/ID_____

Group # _____

Does the child have any medical restrictions? Yes No

Explain

_____

Does the child have any activity restrictions? Yes No

Explain

_____

History

Allergies – list specifics

○ Sinusitis ○ Bronchitis ○ Fainting ○ Upset stomach ○ Kidney trouble ○ Seizures ○ Sleepwalking	○ Heart trouble ○ Diabetes ○ Asthma ○ Bedwetting ○ Dietary restriction ○ Psychological needs

Allergen	Reaction	Treatment
Drug(s)		
Food item(s)		
Plant(s)		
Animal(s)		
Bee/Insect sting(s)		
Other		

Medications	Date of last tetanus shot
Is the child currently taking medications? Yes No	_____

Medication Name	Dosage

Medical and Liability Release

I/we, the undersigned parent or guardian of the above-named child, a minor, do hereby consent to any x-ray, examination, anesthetic, medical, surgical, diagnosis, or treatment and hospital service that may be rendered to said minor under the general or special instruction of the named medical clinic or my child's doctor, or any physician the school or organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called by the school or other organization.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize **the Montana Conference of Seventh-day Adventists** or the physician to exercise the best judgment as to the requirements of such diagnosis or treatment. I/we waive and release the local church, Montana Conference, North Pacific Union Conference, North American Division, and General Conference of Seventh-day Adventists from any and all liability for actions taken on behalf and for the care of the child.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish the General Conference Insurance Service, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions, or treatment, and copies of all hospital medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Parent/Guardian Name Parent/Guardian Signature

Date _____