Emergency Medical Authorization
Maranatha Baptist Church

Child/Teenager Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Alternate Phone Number _____
Date of Birth _____ Social Security # _____
Date of last Tetanus Immunization _____

I authorize any representative of Maranatha Baptist Church to have the power to grant consent to any emergency medical treatment/care, including required tests, to the above named child/teenager if I or the other parent cannot be reached.

Father_____ Home Phone_____
Address_____ Work Phone_____
Mother_____ Home Phone_____
Address_____ Work Phone_____
Relative_____ Home Phone_____
Address_____ Work Phone_____

In the event reasonable attempts to contact the above persons have been unsuccessful, I hereby give my consent for the following local medical care providers and local hospital to be called or child/teenager taken there when within reasonable traveling distance. When not within reasonable traveling distance, or in case of long distance trips or out of state trips, I give my permission for my child/teenager to be treated at the nearest medical facility available.

Doctor_____ Phone_____
Dentist_____ Phone_____
Medical Specialist_____ Phone_____
Hospital_____ Phone_____

This authorization does not cover major surgery unless the medical opinion of a second licensed physician or dentist concurring in the necessity for such surgery is obtained BEFORE THE SURGERY IS PERFORMED.

Facts concerning my childôs/teenagerôs medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted _____
_____
_____
_____

_____ _____
Date Signature of Parent

My Insurance Carrier is_____ Policy # _____