

PARENT/GUARDIAN'S AUTHORIZATION
TO CONSENT TO HEALTH CARE FOR MINOR
AND INDEMNIFICATION AGREEMENT

I, _____, am the custodial parent having legal custody of _____, a minor child, age _____, born _____. I authorize _____, an adult sponsor (hereinafter, Sponsor) in whose care I have entrusted my child to do any acts which may be necessary or proper to provide for the emergency health care of the minor child, including, but not limited to, the power

- (i) To provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such emergency health care, and
- (ii) To consent to and authorize any emergency health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.
- (iii) To give my child Tylenol/Advil, cough syrup, or Pepto-Bismol if needed. Yes No

This consent shall be effective throughout my child's attendance and participation in the Student Convention, including activities preliminary and subsequent thereto, through _____, 20__, or unless specifically extended or rescinded earlier by either party.

In consideration of my child being able to attend and participate in Student Convention, I do hereby agree to hold Accelerated Christian Education, Inc., Student Convention, director, or dean and their agents and employees, harmless from any and all present and future liability, actions, causes of actions, claims, expenses, and damages on account of injury, including death, to my child or property, which is not the result of gross negligence, intentional neglect, or willful or wanton conduct by the Student Convention, director, or dean and their agents and employees, in connection with any medical treatment deemed necessary and authorized by the terms of this Medical Consent Form.

Current Medical Conditions:

(Include nature of any required attention, medications, or other treatment and/or allergies to medication.)

Date of Last Tetanus or Booster: _____

Name of Physician: _____ **Phone ()** _____

Medical Insurance Information: _____ **Policy #** _____
(company name)

Emergency Telephone Number(s): _____

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agents named herein. I further state that I HAVE CAREFULLY READ THE FOREGOING INDEMNIFICATION AGREEMENT AND KNOW THE CONTENTS THEREOF AND I SIGN HEREUNDER AS MY OWN FREE ACT.

Date

Custodial Parent/Guardian's Signature

Custodial Parent/Guardian's Printed Name

Address

City St./Prov. ZIP/Postal Code

Home Telephone

Name of School

School Customer #

School Phone

Sponsor