



Minor Participation Authorization and Consent to Emergency Medical Treatment Form

I, the undersigned, certify that I am the parent or legal guardian of _____ (hereafter the "minor child").

I hereby give my consent to have my minor child participate in the following activity of **Olive Branch Community Church**: _____ (hereafter "the activity") on or about _____, 20____.

I recognize that there are risks involved in participating in this activity and hereby assume all risk of injury, harm, damage, or death to my minor child in connection with his/her participation in this activity.

To the fullest extent permitted by law, I release **Olive Branch Community Church**, its trustees, elders, officers, directors, employees, agents and representatives from any injury, harm, damage or death which may occur to my minor child while participating in the activity and agree to save and hold harmless **Olive Branch Community Church**, its trustees, elders, officers, directors, employees, agents and representatives from any claims arising out of my minor child's participation in the activity.

Further, being the parent or legal guardian of the minor child, I do consent to any medical, surgical, x-ray, anesthetic, or dental treatment that may be deemed necessary for my minor child. I understand that efforts will be made to contact me prior to treatment but, in the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. As parent or legal guardian, I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child. Any insurance policy of the church or organization sponsoring this event will be used as the secondary coverage.

Minor's date of birth: _____

Emergency Contacts *(In case of an emergency, who should we call?)*

(1) Name: _____ Phone : (____) _____

(2) Name: _____ Phone (____) _____

Medical History/Physical Restrictions

Check if a problem or concern (give details on back of sheet if necessary)

☐ Allergies

☐ Frequent Colds

☐ Heart Conditions

☐ Diabetes

☐ Epilepsy or other nervous disorders

☐ Stomach Upsets

☐ Physical Handicap

☐ Asthma

☐ Chronic eye, ear, nose, throat

☐ Hay Fever

Explain: _____

Medication (name and dosage) _____

Date of last Tetanus Shot _____

Any swimming Restrictions? _____ Any activity Restriction? _____

Explain:

Family Doctor _____ Phone _____

Insurance Company _____ Phone _____

Policy Number _____

Executed this _____ day of _____, 20__.

Signature _____

Printed Name _____

Witness: _____

Witness: _____