Ooltewah Baptist Church
CREATIVE LEARNING PROGRAM

Medical Treatment Authorization

Child's Name:_____ Date of Birth:_____

Parent's/Guardian's Names: _____

Home# _____ Cell# _____ Work# _____

Child's Physician: _____ Phone: _____

Hospital Preference: _____

Health Insurance Carrier: _____

Name and Social Security # of Insured: _____

Policy/Group #'s: _____

Please list any known illness, condition, or allergy your child has:_____
_____

Please list any medications your child takes regularly: _____

_____

I hereby authorize the Creative Learning Program staff of Ooltewah Baptist Church to obtain any medical or surgical care necessary for the above named child and grant permission for the physician or designated professional to provide that care.

_____
Parent Signature Date