



**AUTHORIZATION FOR MEDICAL TREATMENT FOR MINOR
(Must be completed for everyone under the age of 18)**

The undersigned certifies that he/she is the parent or legal guardian of: _____
that the named individual is a minor, was born _____ and has his/her consent and permission to be
traveling to _____ with First Pentecostal Church (FPC) from
_____, 20____ to _____, 20_____.

In the event of accident, illness or the necessity of medical treatment of the above named minor child, if the
parent(s) or legal guardian(s) cannot be immediately contacted, the undersigned fully authorizes any member of
the FPC staff and/or supervisory personnel of the facilitating department of First Pentecostal Church to act as
agent to do as follows:

1. To arrange for transportation, whether by ambulance or otherwise, to a proper facility where emergency medical
treatment or any other health care treatment would normally be administered, including, but not limited to, an
emergency room hospital, a doctor's office, or a medical clinic; and
2. To consent to and arrange for the administration of any treatment deemed necessary or advisable, including, but not
limited to, any x-ray examination, anesthetic, medical or surgical diagnosis, medical or surgical treatment, and
hospital care, to be rendered under the general or special supervision and on the advice of any attending physician,
surgeon, or other health care provider; and
3. To sign any releases or documents necessary in order to obtain any medical, surgical, or other health care
treatment as is required In the judgment of the medical authorities, attending physician, surgeon, or other health
care provider.

This Authorization for Medical Treatment for Minor shall be valid and in full force and effect until (LAST DAY OF
TRIP) _____, 20____. Notwithstanding the above, this Authorization for Medical Treatment shall be
valid and in full force; if, due to continuing medical treatment, the Minor is unable to return from the above-mentioned tour,
until such date as the Minor is able to return from the tour. This instrument may be revoked by written notice delivered to the
above-named agent prior thereto. In witness whereof I have voluntarily signed this document as my own free act in the
State of Florida, County of _____ on this _____ day of _____, 20_____.

Sign ONLY in the presence of a Notary Public.

Parent/Guardian _____ Parent/Guardian _____

As Representative on Behalf of Minor Child _____ (printed name)

Minor Child's Signature: _____

Certificate of Acknowledgment - This portion must be filled out by a Notary Public.

State of Florida _____ County of _____

The foregoing instrument was acknowledged before me via physical presence OR online notarizations this _____
day of _____ 20____, which is the date of the execution of this Authorization for Medical Treatment for
Minor, by (MINOR CHILD) _____ and the parent(s)/legal
guardian(s) _____ who is personally known OR produced identification. Type of
identification produced _____ proving them to be the individual described in and who executed this
document, and acknowledged that he/she fully understands its contents and meaning and duly executed the same as his/her free
act and deed and for the sole consideration therein stated.

Notary Public: _____ Printed Name: _____

My commission expires: _____