

# WESTERN HILLS CHURCH OF CHRIST

8800 Chapin Rd. Fort Worth, Texas 76116 Phone: 817-244-0132

## MEDICAL TREATMENT AND RELEASE AUTHORIZATION

I, \_\_\_\_\_, do hereby constitute and appoint all sponsors of Western Hills Church of Christ my lawful agent, and in my name, place, and stead to consent to any therapeutic procedure or medical services that in his/her judgment may be advisable for the well-being of my child,

\_\_\_\_\_ as a result of illness or injury. This authority is limited in duration to the period of \_\_\_\_\_ while on their trip to \_\_\_\_\_.

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Please list any known allergies which your child has: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications which your child will be taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any additional physical or emotional problems that your child may have which we should know about and how treatment should be administered on the reverse side of this form.

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I, \_\_\_\_\_, give my permission for my child, \_\_\_\_\_, to accompany the Western Hills Church of Christ to \_\_\_\_\_ on \_\_\_\_\_ and return on \_\_\_\_\_.

\_\_\_\_\_. I understand that the sponsors are not responsible and I will not hold them or any member of the Western Hills Church of Christ responsible for any action of my child.

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Health Insurance Company Policy # \_\_\_\_\_

Name of policy holder: \_\_\_\_\_

Phone # for pre-certification: (\_\_\_\_) \_\_\_\_\_

Father's work #:(\_\_\_\_) \_\_\_\_\_ Mother's work #:(\_\_\_\_) \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Parent

Please attach a copy of the front and back of your insurance card. Thank You!