

**First Presbyterian Church of Atlanta**  
**Consent for Emergency Treatment, Diagnostic Testing and/or**  
**Admission to Appropriate Hospital/Medical Facility**

I, \_\_\_\_\_, hereby, consent for \_\_\_\_\_  
(Name of Custodial Father/Mother or Legal Guardian) (Youth Leader's Name)  
to give permission for the necessary medical services, treatment and procedures  
performed by physicians, employees of the hospital and or health care personnel, in  
training as ordered by and under the supervision of the attending physician, or supervised  
by authorized hospital personnel for :

\_\_\_\_\_ while on an authorized trip with First Presbyterian  
(Name of Child or Children) Church of Atlanta.

I hereby acknowledge that no warranty or guarantee have been made to me as to the  
effect of such examinations or treatment on the child's condition. I acknowledge that I am  
financially responsible for all charges in connection with care and treatment rendered to:

\_\_\_\_\_  
(Name of Child or Children)

Signature: \_\_\_\_\_ / \_\_\_\_\_  
(Custodial Father/Mother or Legal Guardian) (Date)

State of \_\_\_\_\_

County of \_\_\_\_\_

**Notary Required!!!!!!**

Taken, subscribed and sworn to before me, a notary public  
In said country, this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.  
My Commission expires \_\_\_\_\_.

\_\_\_\_\_  
(Notary Public Signature)

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**Important Instructions for Completion/Use of Consent for Treatment Form:**

1. The Custodial Father/Mother or Legal Guardian **must sign** the form in the presence of a Notary Public.
2. This form **will not be accepted** if not notarized by legal notary.
3. Form must accompany patient at time of treatment.
4. A copy of Custodial Father/Mother or Legal Guardian's **Medical Insurance Card must be attached. (both sides)**

**Please complete Information on reverse side for treatment purposes.**

**Important Information for Treatment**

Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Father's **Full** Name \_\_\_\_\_ Employer \_\_\_\_\_  
Father's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Telephone (Business) \_\_\_\_\_ (Cell/Pager) \_\_\_\_\_  
Mother's **Full** Name \_\_\_\_\_ Employer \_\_\_\_\_  
Mother's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Telephone (Business) \_\_\_\_\_ (Cell/Pager) \_\_\_\_\_

**Attach a Copy of Medical Insurance Card**

Person to contact in case of emergency \_\_\_\_\_  
Phone numbers \_\_\_\_\_  
Relationship \_\_\_\_\_  
Family Physician \_\_\_\_\_ Telephone \_\_\_\_\_

**Information Needed for Youth Participant(s)**  
(May be used for multiple children)

Youth Full Name \_\_\_\_\_ SS# \_\_\_\_\_ Birthday \_\_\_\_\_  
List specific medical problems: \_\_\_\_\_  
\_\_\_\_\_  
List all allergies: \_\_\_\_\_  
\_\_\_\_\_  
List all medications (prescriptions/OTC drugs): \_\_\_\_\_  
\_\_\_\_\_  
List any medical conditions/history that we should be aware of: \_\_\_\_\_  
\_\_\_\_\_  
Date of Last Tetanus: \_\_\_\_\_ **(required information)**  
Are Immunizations up to date? \_\_\_\_\_ (date of last immunizations)

Youth Full Name \_\_\_\_\_ SS# \_\_\_\_\_ Birthday \_\_\_\_\_  
List specific medical problems: \_\_\_\_\_  
\_\_\_\_\_  
List all allergies: \_\_\_\_\_  
\_\_\_\_\_  
List all medications (prescriptions/OTC drugs): \_\_\_\_\_  
\_\_\_\_\_  
List any medical conditions/history that we should be aware of: \_\_\_\_\_  
\_\_\_\_\_  
Date of Last Tetanus: \_\_\_\_\_ **(required information)**  
Are Immunizations up to date? \_\_\_\_\_ (date of last immunizations)