

**CONFIDENTIAL**

TRINITY LUTHERAN CHURCH – FARIBAULT, MN

LUTHERAN YOUTH FELLOWSHIP - AUTHORIZATION for MEDICAL TREATMENT

for: \_\_\_\_\_

Primary Doctor/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

I will provide supervisors with any medications my child may need to take during an activity/event.

My child is currently taking the following medications and/or supplements:

\_\_\_\_\_  
\_\_\_\_\_

My child has the following allergies, health conditions or medical needs:

\_\_\_\_\_  
\_\_\_\_\_

Other issues that could affect my child’s well-being:

\_\_\_\_\_  
\_\_\_\_\_

If I cannot be reached in the event of an emergency with my child, I authorize:

- adult supervisors to administer emergency aid and/or obtain necessary medical treatment child.
- health care providers (ambulance, ER, physician, etc.) to treat my child as necessary.
- release of medical information by primary provider(s) above as needed to treat my child.

I agree to be responsible for cost of treatment by a health care provider.

Medical insurance: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/legal guardian