



Christ the King Retreat Center

Medical Consent and Permission to Treat

This form should be filled out for each participant and sponsor.

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. In case of an emergency, this form should accompany the person to the emergency facility.

Name: _____

Date of Birth: _____ Male: _____ Female: _____

List any drug allergies: _____

Please list any medications that are required include directions, dosage, frequency, and storage.

Med. #1: _____

Med. #2: _____

Med. #3: _____

(if additional space is needed, please use a separate sheet of paper)

In the Event of an Emergency, please list your preferred contact information:

1st contact:

Name: _____ Relationship: _____

Home Address: _____

Contact Number 1: _____ Contact Number 2: _____

2nd contact:

Name: _____ Relationship: _____

Home Address _____

Contact Number 1: _____ Contact Number 2: _____

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I grant my authorization and consent for Name of Designated Adult _____ (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury of illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

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****Please include a photocopy of your Health Insurance Card, front and back along with this form.**

Insurance Carrier: _____ Policy Number _____
Family Doctor: _____ Phone Number _____

_____ Immunizations are current and up to date.

Note any other significant medical information, ie: Seizures, Diabetic, etc.: _____

I understand that Christ the King Retreat Center does not have nor will administer any non-prescription medication, i.e.; (Cough Drops, Tylenol, Cough Syrup, etc.)

This authorization is effective beginning: _____, AM/PM _____, _____
Time Date Year
And ending on _____, AM/PM _____
Time Date Year

Signature of Parent/Guardian _____ Date: _____

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