

EMERGENCY INFORMATION AND MEDICAL AUTHORIZATION

Purpose of the following information: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under church authority, *when parents or guardians cannot be reached.*

In the event reasonable attempts to contact me at (phone #) _____ have been unsuccessful, I hereby give my consent for: (1) The administration of any medical treatment deemed necessary by (physician) Dr. _____ at phone # ____ or (Dentist) `Dr. _____ at phone# _____ or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to (preferred hospital) _____ or any other hospital reasonably accessible.

Facts concerning the child’s medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted:

I do not give consent for church authorities to contact any medical professionals in the event of an emergency.

Parent/Guardian
Signature:

Date



***Please turn in registration forms to the church office, located at 1 Doll Rd Reeders PA 18352**
Should any circumstances arise, please feel free to contact Pastor Pedro Fabian at
(570)-629-7880. Primera Iglesia Hispana de los Poconos. Asamblea de Dios..