

## Medical Consent Form

I hereby give permission to the adult leaders of this trip to authorize any medical treatment that they deem is necessary for the well-being of my child. I agree to hold Divine Savior Lutheran Church, its leaders and the adults associated with this trip, harmless in any and all claims arising from the administration of medical treatment for my child. I further understand that the cost of such medical treatment will be borne by the parent/ guardian's insurance and/ or the parent/ guardian themselves.

Youth Name: \_\_\_\_\_

Parent/ Guardian Name: \_\_\_\_\_

Parent/ Guardian Phone Number: \_\_\_\_\_

Parent/ Guardian signature: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

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

Policy Holder's Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Please attach a copy of your insurance card to this sheet if possible.

In case of emergency, please contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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Prescription / Non- Prescription medication to be taken:

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

Allergies to medications:

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

Relevant Medical Information:

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