



## AUTHORIZATION FOR MEDICAL TREATMENT

I, \_\_\_\_\_ **(Parent/Guardian)** am the parent or legal guardian of  
\_\_\_\_\_ **(Student)** (hereinafter "my child"). My child is  
attending and participating in activities at/with Dayton United Methodist Church located at: in the City of  
Dayton, County of Tippecanoe, and State of Indiana, beginning on the day of June 1, 2020.

I hereby authorize Pastor Caleb and the Overhaul Leadership Team and their officers, agents, servants, or  
employees that are 18 years of age or older, who supervise the activities at Dayton United Methodist Church,  
into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child.  
The authority granted by this authorization includes the authority to consent to any x-ray examination,  
anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special  
supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical  
Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical  
diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize the Pastor Caleb and the Overhaul Leadership Team and their officers, agents, servants, or  
employees that are 18 years of age or older, who supervise the activities at this Dayton United Methodist  
Church to receive physical custody of my child, upon completion of any treatment, and I specifically instruct  
any treating health facility to surrender physical custody of my child to Pastor Caleb and the Overhaul  
Leadership Team a his/her officers, agents, servants, or employees that are 18 years of age or older who  
supervise the activities at Dayton United Methodist Church CM0169 (04-2020) -2- It is understood that this  
authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is  
given to provide authority and power on the part of the supervisor or his/her authorized designee, in the  
exercise of his/her best judgment, upon advice of such physician, dentist, and surgeon, may deem advisable.

\_\_\_\_\_  
**(SIGNATURE OF PARENT OR GUARDIAN)** **DATE:** \_\_\_\_\_

### ADDITIONAL INFORMATION:

\_\_\_\_\_  
Medical/Health Insurance Company

\_\_\_\_\_  
Insurance Policy Number

\_\_\_\_\_  
Allergies/Allergic Reactions of my child

\_\_\_\_\_  
Medications being taken by my child

\_\_\_\_\_  
Other information regarding my child's health that a doctor should know.