Foursquare Missions “GO” Team

Managua, Nicaragua

EMERGENCY MEDICAL CARE TO MINOR

I/We the undersigned parent(s) or legal guardian to the minor

____ __________________

Name ***Birth Date***

do hereby authorize any necessary examination, anesthetic, dental, medical or surgical diagnosis or treatment by any duly licensed physician or dentist and hospital service that may be rendered to said minor under the guardian, specific, or special consent of:

Foursquare Missions “Go” Team Leaders

the temporary custodian of the said minor; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at the licensed hospital. I/We authorize the physician or dentist to call in any necessary consultants an his/her best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment. It is further understood that those persons who have temporary custody of said minor will attempt to talk with the parent(s)/legal guardian via the telephone numbers listed below before treatment is rendered.

Dates of Consent: ________to ________

One parental signature is required:

Father:____

Mother:____

Legal Guardian:____________________________________

Address:____

Daytime phone:__________________ Evening phone:_________________

Person(s) to be reached if parent/guardian cannot be contacted:

Name:_________________________ Phone:________________

Name:_________________________ Phone:________________

To your knowledge, is your child allergic to any medication?_____ Is so, what?

Will your child be taking any medications (prescription or otherwise) while in the care of the above temporary custodian?_____ If so, what medications?

Does your child have diabetes, hypoglycemia or other medical disorder which the adult leader should be aware?_____ If so, what?

Medical Insurance Company:___________________________ Policy#___________________