

# Medical Consent Form

Christ Church Cathedral  
55 Monument Circle #600  
Indianapolis, IN 46204  
317-636-4577

Childs' Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: (optional) \_\_\_\_\_

## Parent or Guardian Information

1. Parent or Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2. Parent or Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## If parent or guardian is not available, in case of an emergency please notify:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ WorkPhone: \_\_\_\_\_

Does this child have any of the following allergies, if so please check:

Insect Stings     Poison Ivy     Hay Fever     Nuts

Penicillin    Other allergies (please list) \_\_\_\_\_

Other drugs (please list) \_\_\_\_\_

No Medical Insurance

## Medical Information

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

## Dental Information

Dentist Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

**Medical Insurance Information**

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_

Policy Holders Social Security Number (optional) \_\_\_\_\_

Policy Number: \_\_\_\_\_

Phone number of Insurance Company: \_\_\_\_\_

(Please attach copy of medical card)

Date of Child's last Tetanus shot: \_\_\_\_\_

Are there any activities, to be restricted for this child? [ ] No [ ] Yes

If so, please describe: \_\_\_\_\_

Is this child on any medications [ ] No [ ] Yes

If so, please describe: \_\_\_\_\_

Other Comments or suggestions from the parent or guardian concerning this child: \_\_\_\_\_

We (I) understand that, in the event my child requires medical or dental treatment while engaged in an activity, reasonable efforts will be made to contact me, however, if we (I) cannot be reached, we (I) hereby consent and give permission to the ministry's sponsor or any adult advisor acting on behalf of the ministry with respect to the activity, as agent for me, to consent to any medical exam, x-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, we (I) have listed above all of my child's medical allergies, medications being taken, medical problems and any other pertinent information.

We (I) further understand that **Christ Church Cathedral** carries medical and hospitalization insurance coverage which, consistent with the exclusions, limitations and terms thereof, may provide benefits over and above any personal medical and hospitalization coverage's available to my family. We (I) understand that any personal medical and hospitalization insurance available to my family will provide primary coverage and the Cathedral's medical and hospitalization coverage (subject to exclusions, limitations and provisions in the Cathedral's policy) may provide secondary or excess coverage. We (I) agree to apply first for benefits that may be available from the families medical and hospitalization coverage.

We (I) understand that should it be necessary for our (my) child to return to my care due to medical reasons or otherwise, that I shall assume all transportation costs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or Guardian)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_