First Baptist Church P.O. Box 25 Abington, Massachusetts 02351 Tel. (781) 878-2447
www.abingtonfbc.com

# AUTHORIZATION TO TREAT MINOR

We, the undersigned Parent (s) or Guardian (s) of
_____
a minor, do hereby authorize adult workers with youth of the First Baptist Church, North Abington, MA as agent(s) for the undersigned, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis' or treatment and hospital care which is rendered under supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

YOUTH'S DATE OF BIRTH ___ ___ / ___ ___ /____ ____ ___ _____
M M D D C C Y Y

FATHER'S NAME _____

MOTHER'S NAME _____

ADDRESS _____

CITY/ TOWN _____ ZIP ____ ____ ____ ____ _____

HOME PHONE ( ___ ____ ____) ___ ____ ____ - ____ ____ ____ ___

CELL / WORK NUMBERS _____
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OTHER NUMBER FOR EMERGENCY CONTACT (__ __ __) __ __ __ - __ __ __ __
NAME _____RELATIONSHIP _____

DO YOU HAVE HOSPITALIZATION INSURANCE? (CIRCLE ONE) YES NO
NAME OF INSURANCE COMPANY _____
POLICY NUMBER _____
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PERTINENT MEDICAL HISTORY _____

_____

LIST ALL KNOWN ALLERGIES: _____

_____
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SIGNED: _____

RELATIONSHIP TO YOUTH: _____

DATE __ __ / ___ ___ / ___ ___ ___ ____

**** PLEASE NOTE: All reasonable effort will be made to contact the Parent(s) or Guardian(s) of the child. This authorization would be only used in the event of a crisis or in the situation of an extreme emergency, where time was critical for effective treatment.