

CONSENT FOR MEDICAL TREATMENT OF MINOR

I, _____, am the parent or legal guardian
of _____, who was born on _____, 19_____.

I warrant that I possess all the rights, powers, and privileges of a parent or legal guardian necessary to execute this document with binding legal effect.

I consent to the examination or treatment of my child by a physician duly licensed to practice medicine in the State of _____ or any health care professional duly licensed to provide health care services in the State of _____ for medical care and service deemed necessary by Filipino-American Christian Fellowship, its agents, servants, and employees.

I give permission to the Doctor or health care professional to provide any and all medical care they deem, in their professional opinion, to be necessary.

I understand and acknowledge that my permission and consent is sufficient for this purpose. I represent to Filipino-American Christian Fellowship that no permission or consent from any other person is required by law.

I agree to pay for any and all medical expenses incurred as a result of the use of this consent.

I understand that it is my obligation to inform the management of Filipino-American Christian Fellowship of any and all health considerations or medical conditions that would restrict my child's participation in any and all activities while at Filipino-American Christian Fellowship or involving Filipino-American Christian Fellowship or its programs.

Signature of parent or guardian
Date

Print or type name

Note: Should the need for medical attention arise, Filipino-American Christian Fellowship will attempt to contact you, as soon as practicable under circumstances.