

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Name of minor: _____

I, _____ (parent, guardian, managing conservator) giving consent, authorize medical treatment of the above named minor to include, without limitation, x-ray examination, anesthesia, medical, dental or surgical examination or treatment, general hospital care or first aid. No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from the delay of treatment need be made under this authorization. The possession of this authorization by an adult is evidence that the adult has care and control of the above named minor. I will indemnify and hold harmless from any expenses or claims of any nature any entity which provides or causes to provide examination, treatment, first aid or hospital care pursuant to this authorization and conditionally agree to make or cause to be made, by assignment of third party benefits or otherwise, full and complete payment for such examination, treatment, first aid or hospital care. I will additionally hold harmless any adult in charge for any treatment decision. I am the person having the power to consent to this authorization. This authorization shall remain in effect for as long as the minor is involved in Royal Rangers activities. This authorization shall also be applicable to conditions arising during transportation to and from church activities. I have no religious scruples against any standard medical treatment.

Name & signature of person giving consent: _____ Date: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Emergency Phone: _____

Minor(s) IS _____ IS NOT _____ covered with medical insurance?

Insurance Company: _____ Policy no.: _____

Principle insured & S.S. No.: _____

Family Physician: _____ Phone No.: _____

List minor name, birthdate, social security no.:

Name: _____ Birthdate: _____ SS#: _____

South Texas District Royal Rangers

Notary information:

South Texas District Royal Ranges Medical Record (One Form Per Person)

Name: _____ Age: _____ Date of Birth: _____

Church Name: _____ Outpost #: _____

GENERAL HEALTH HISTORY: To be completed by the Parent/Legal Guardian. Answer "Yes" or "No" to the following and briefly explain all Yes answers under "Remarks".

Sinus Condition		Shortness of Breath		Exposed to Infectious Disease within the past three weeks?	
Ear problem		Skin Infection		Exposed to Hepatitis within past six months?	
Lung problem		Hearing Difficulty		Any known Reaction to Drugs or Medications of any type?	
Heart Trouble		Bad Eyesight		Taking Prescription Medicine?	
High Blood Pressure		Do you wear Contact Lenses		Any Physical Restrictions from Normal Outdoor Activities	
Allergy - Asthma		Any Medical care within past year?		Any disorder preventing Strenuous Activity	
Fainting or Dizzy Spells		Any Surgery within past year?		Food Allergies	
Diabetes		Disorders that would prevent strenuous activity?		Other:	

REMARKS AND MEDICAL FACTS WE SHOULD KNOW IN CASE OF EMERGENCY:

Use back of form if more space is needed.

Give latest date (if known) of Inoculation or Vaccination against the following:	Tetanus	Small Pox	Measles	Typhoid	Diphtheria	Polio
Physician's Information: Name: Address:				Area Code and Phone Number		
Person to notify in case of emergency: Name & Relationship: Address:				Area Code and Phone Number		

Signature: _____ Date: _____