

Participant Medical Form  
First Presbyterian Church of Ft. Thomas, June 11th-17th, 2006  
AUTHORIZATION FOR MEDICAL TREATMENT

**PARTICIPANT INFORMATION (ONE PER PARTICIPANT)**

Participant Last Name	First Name	MI
Insurance Company	Policy and Group Number	
Policy Holder's Name (Last, First)	Insurance Authorization Phone Numbers	
Emergency Contact	Emergency Contact Phone Number	

**Please list any special medical information, including medication, on the reverse side (youth and adults) and attach copy of front and back of insurance card. This information will be kept confidential**

I understand and agree that my insurance will be available for the payment of expenses in connection with any medical care and that I remain responsible if no insurance is available. This grant of authority shall be in affect from the dates set forth here-in-below until the end of the 2006 First Presbyterian Mission Trip. This form has been fully explained to me, and by my signature I hereby certify that I have read and fully understand this Authorization For Medical Treatment.

Signature \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION (Must be completed for youth 18 and under)**

Child's Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Entering Grade \_\_\_\_\_ Name of adult attending the conference with \_\_\_\_\_

I, \_\_\_\_\_ of \_\_\_\_\_  
Print parent/legal guardian's full name Print complete mailing address

As parent or legal guardian of the above named person, do hereby consent to and authorize the staff persons and officials of the 2006 First Presbyterian Koinonia Mission Trip to obtain, under emergency conditions, any x-ray examination, anesthesia, diagnosis, medical or surgical treatment or hospital care to be rendered to my minor son/daughter under the supervision and on the advice of any physician or medical professional. It is my intent that in case of emergency no medical treatment be delayed or withheld from my son/daughter due to my absence or unavailability. Further, I agree to hold harmless The First Presbyterian Church, its related entities, staff, agents, and volunteers from any and all liability, claims, and causes of action which may arise from the good faith decisions acting under this Authorization For Medical Treatment to my minor son/daughter. I understand and agree that my insurance will be available for the payment of expenses in connection with such medical care and that I remain responsible if no insurance is available. This grant of authority shall be in affect from the dates set forth here-in-below until the end of the 2006 First Presbyterian Church Mission Trip. This form has been fully explained to me, and by my signature I hereby certify that I have read and fully understand this Authorization For Medical Treatment.

**ON BACK:** Please report any medication brought or treatment, including allergies, to be continued at the conference.  
**INSTRUCTIONS FROM A DOCTOR MUST BE SIGNED BY THE DOCTOR. Information will be kept confidential.**

Signature of Parent or Legal Guardian \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_