Candlelight Christian Fellowship
5725 N. Pioneer Drive, Coeur d'Alene, ID 83815 (208) 772-7755

Medical Consent Form for Minors

Date:_____

Name of youth:_____ Birth date: _____

Name of parent(s) or Legal Guardian(s): _____

Address:_____

Phone #: _____ Work Phone #:_____

Other person to call in emergency:_____ Phone#:_____

Medical Information

Is your youth presently being treated for an injury or sickness or taking any medication? ☐ Yes ☐ No

If yes, please explain:_____

Does your youth have, or has your youth ever had, any of the following? (Please check all that apply.)

☐Asthma ☐Hay Fever ☐Kidney Disease ☐Diabetes ☐Heart Murmur ☐Seizure Disorders ☐Allergies ☐Other

If yes, please explain: _____

Youth's blood type_____ (if known)

Does your youth have a physical handicap or illness that would prevent him or her from participating in normal activity?

☐Yes ☐No If yes, please explain._____

Family Doctor (If Applicable):_____ Doctor's Telephone (If Applicable):_____

Insurance Co. & Policy #: Name: _____ Policy #:_____

Consent and Certification

I, the undersigned, being the parent or legal guardian of the youth named above, do hereby consent to the participation of my youth in the activities of Candlelight Fellowship, Inc. (also known as Candlelight Christian Fellowship). Further, I certify that my youth is physically fit and adequately prepared to participate in all recreational events. If I wish to revoke or update this consent for any reason, I will promptly notify Candlelight Christian Fellowship in writing.

Medical Treatment Authorization

I understand that I will be notified in the case of a medical emergency. However, in the event that I cannot be reached, I authorize the calling of a doctor and/or the providing of necessary medical services in the event that my youth is injured or becomes ill. I authorize the pastoral staff of Candlelight Christian Fellowship, or another adult chaperone designated by the pastoral staff, to make emergency medical care decisions such as appropriate x-ray examinations, anesthetic, medical or surgical diagnosis or treatment, and hospital care on behalf of my youth. Furthermore, I give Candlelight Christian Fellowship staff permission to administer medications as needed per directions given. (Attach directions or write them on the back of this form.)

I understand that Candlelight Christian Fellowship will not be responsible for medical expenses incurred solely on the basis of this authorization. I further agree to notify the church of any health changes that would restrict my youth's participation in any activities. I also understand that the designated adult chaperones reserve the right to restrict my youth from any activity that they do not feel is within the physical capabilities of my youth.

Signature of Parent or Legal Guardian_____ **Date**_____

(Form must be updated and signed every 2 years) Jan 23, 2020