

**Consent for Medical Treatment
First Presbyterian Church, Marshfield, WI**

As the parent or legal guardian of _____, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine, Doctor of Dentistry or other medically qualified emergency medical personnel. This care may be given under whatever conditions are necessary to preserve life, limb, or well being of my dependent. This authorization will be in effect from _____ to _____ (one year max). Parent or guardian may revoke this consent in writing at any point during the year. It is the responsibility of the parent or legal guardian to inform First Presbyterian Church of Marshfield of any changes.

Date: _____

Parent/Legal Guardian signature: _____

Best daytime phone number: _____

Best evening/nighttime phone number: _____

Allergies: _____

List reaction to known allergies: _____

Medications: _____

Medical conditions: _____

Insurance Co _____

Subscriber or Policy Number _____

Group Number _____