AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT AT ANY MEDICAL FACILITY

Date_____

Authorization is hereby given to HARVEST MINISTRY TEAMS, INC.
Name of Responsible Person

to consent to emergency treatment for _____
Name of team member

And to proceed with such treatment that may be necessary in that the cardholder is not available at the time of the injury or illness.

Authorization is also given for admission to the hospital, if at time of injury or illness, admission to the hospital is advised by a consulting physician.

Age of team member_____Date of birth_____

Address_____Phone_____

City_____ST_____Zip_____

Parents' names & work phone numbers_____

_____

Date of last tetanus immunization injection_____

Please list any allergies_____

Name of Family Physician_____

Telephone Number of Physician_____

If parents are unable to be contacted, please list another person who can be reached:

_____

I, the cardholder, promise to pay whatever costs are not covered by:

_____
Name of Insurance Company | Policy Number on Card

_____ _____
Signature of Cardholder | Signature of Team Member

Subscribed and Sworn to before me on
this _____day of_____,
20__. Witness my hand and official seal.
Notary Public_____
My Commission Expires:_____