

# FAITH WORKS PROJECT

James 2:18 - But someone will say, "You have faith; I have deeds." Show me your faith without deeds, and I will show you my faith by my deeds.

A 501c3 Non-denominational Christian Ministry

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## Authorization of Consent to Treatment of a Minor

I, \_\_\_\_\_, being the parent or legal guardian of

\_\_\_\_\_  
*(Full Name of Minor (Type or Print Clearly))*

\_\_\_\_\_, hereby authorize the "Faith Works Project" officer or other adult representative of "Faith Works Project", into whose care I have entrusted my child, to consent to any x-ray, examination, anesthetic, medical treatment, hospital, or surgical care that may be required for my child in case of any emergency during any travel or activity in connection with "Faith Works Project". I understand that all reasonable attempts will be made to contact me.

\_\_\_\_\_  
*(Signature of Parent or Guardian)*

\_\_\_\_\_  
*Date:*

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

### **PERSON TO NOTIFY IF PARENT OR GUARDIAN IS NOT AVAILABLE**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

### **PERTINENT MEDICAL HISTORY** (ANY DRUG, FOOD, OR ENVIRONMENTAL ALLERGIES, PREVIOUS ILLNESS OR INJURY, ACTIVITY LIMITATIONS)

\_\_\_\_\_  
\_\_\_\_\_  
MINOR'S PHYSICIAN: \_\_\_\_\_

PHYSICIAN Telephone: \_\_\_\_\_

MEDICAL INSURANCE CARRIER: \_\_\_\_\_

ID# / GROUP / ACCOUNT NUMBER: \_\_\_\_\_