Arkansas-Oklahoma Synod

Authorization for Medical Care of Participant For Calendar Year 2025

I, the undersigned parent or legal guardian of _____, a minor child, DO HEREBYAUTHORIZE _____ TO CONSENT to any x-ray examinations, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon advice of a physician, surgeon or dentist licensed under the laws of the states of Arkansas and Oklahoma.

IN GIVING THIS CONSENT I RECOGNIZE AND UNDERSTAND that in situations where the above named minor requires immediate medical or hospital care, it may not be possible to contact me. In such situations, I will not be able to knowledgeably evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his/her professional judgment and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he/she in his/her professional judgment determines to be necessary for the health and safety of the above named participant.

I also understand this covers consent for all activities for the above named minor through the Arkansas-Oklahoma Synod Lutheran Youth Organization.

This authorization will be in effect from January 1, 2025 to December 31, 2025. It is my responsibility to make updates and changes as necessary. This authorization may be revoked at any time with notice in writing to Becca Middeke-Conlin, Director for Evangelical Mission/Assistant to the Bishop for Youth & Family, Arkansas-Oklahoma Synod, and the Evangelical Lutheran Church in America.

_____ _____

Signature **Date**

Youth's Address: _____

City: _____ **ST:** _____ **Zip Code:** _____

Parent's Name: _____ **Cell Number:** _____

Work Number: _____ **Email:** _____

Parent's Name: _____ **Cell Number:** _____

Work Number: _____ **Email:** _____

Emergency contact name:_____**Phone:** _____

Contact's Relationship to Youth: _____

Treatment Information

Insurance carrier's name:_____**Policy number:** _____

Insured's name & relationship to minor: _____

_____

Physician's name: _____

Physician's phone number: _____

Participant's birth date: _____ **Date of last Tetanus shot:** _____

List any known allergies and reactions: _____

_____

List medications participant is currently taking including frequency: _____

_____

Participant's pertinent medical history: _____

_____

_____

_____

_____

Please provide a copy of the front and back of the insurance card. This copy will remain in confidence with this form until the end of the calendar year or until changes are made by you.

++End of Medical Authorization++