

CONSENT FOR TREATMENT (minor)

FORM 4b

GENERAL INFO:

Minor's Name:						
[PLEASE PRINT]	First	Middle	Last			
Parent or Guardian:						
[PLEASE PRINT]	First	Middle	Last			
Date of Birth:		Passport Number:		Passport Expires:		
Home Address:					City:	
State/Province:		Zip/Postal		Country:		
Home Phone:		Email Address:				
Parent's Cell Phone:		Parent's Email Address:				
Event:	<input type="checkbox"/>	Homes of Hope	<input type="checkbox"/>	Mission Adventures	Dates:	
Team Name:						

EMERGENCY CONTACT:

Emergency Contact:						
[PLEASE PRINT]	First	Middle	Last			
Relationship to Minor:					Emergency Phone:	

MEDICAL INFO:

Any Allergies?	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	If yes, please describe:				
Taking Medication?	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	If yes, please describe:				
Date of last tetanus inoculation:				Has childhood series of 3 DPT shots been given?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Do you have any conditions that would restrict you on this missions trip?						<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, please specify:									
How would you rate your overall health condition?	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	

AUTHORIZATION AND CONSENT TO EMERGENCY MEDICAL TREATMENT

I give my permission for my minor child identified above to attend the above YWAM event. As parent or legal guardian of this minor child, in the event of an emergency, I hereby give my permission for my minor child to receive any emergency medical treatment deemed necessary by a physician.

Signed:		Dated:	
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