

**Lakeview Christian Center**  
5885 Fleur De Lis Dr. New Orleans LA 70124

**CONSENT TO PARTICIPATE, RELEASE, and MEDICAL AUTHORIZATION**

Name of Minor Child: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Event: **Youth Camp**                      **July 2 – July 6, 2009**

I/We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give Lakeview Christian Center staff (herein referred to as LCC) the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization relieve the physician, dentist, person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that LCC shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by LCC. I understand that this form is in effect from the date signed and that it is my responsibility to inform LCC of any changes to this form. **It is my understanding that this form also serves to establish my consent and permission for the above-named minor to participate in LCC programs, private instruction, and courses.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: : \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: : \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Minor's Last Tetanus Shot: \_\_\_\_\_ (if known) List Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_  
\_\_\_\_\_

Medical history or other important fact that should be known:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_