CHRISTIAN FAITH FELLOWSHIP CHURCH
3188 ROUTE 94, FRANKLIN, NJ 07419
(973) 209-7786 WWW.CFFCHURCH.ORG

Consent for Medical Treatment of Minor

I, _____ am the parent or legal guardian of

_____ who was born on _____.

I warrant that I possess all the rights, powers and privileges of a parent or legal guardian necessary to execute this document with binding legal effect.

I consent to the examination of my child by a physician duly licensed to practice medicine for medical care and services deemed necessary by Christian Faith Fellowship Church, its agents, Servants, and employees.

I give permission to the Doctor or health care professional to provide any and all medical care they deem, In their professional opinion, to be necessary.

I understand and acknowledge that my permission and consent is sufficient for this purpose. I represent to Christian Faith Fellowship Church that no permission or consent from any other person is required by law.

I agree to pay for any and all medical expenses incurred as a result of the use of this consent.

I understand that it is my obligation to inform Christian Faith Fellowship Church of any and all health considerations or medical conditions that would restrict my child's participation in any and all activities involving Christian Faith Fellowship Church.

Dated: _____ 20_____.

_____
(Signature)

_____
(Typed or Printed Name)

Should the need for medical attention arise, Christian Faith Fellowship Church will attempt to Contact you, as soon as practicable under circumstances.

MEDICAL INFORMATION

NAME_____ **DATE OF BIRTH_____**

PERSON TO NOTIFY, In Case of Emergency:

NAME:_____

RELATIONSHIP:_____

ADDRESS:_____

CELL PHONE:_____ HOME PHONE:_____

MEDICAL CONDITIONS_____

_____

_____

MEDICATION CURRENTLY TAKING_____

_____

_____

ANY KNOWN ALLERGIES_____

_____

BLOOD TYPE, if known_____

PHYSICIAN'S NAME_____

ADDRESS_____

MEDICAL INSURANCE_____

INSURANCE #_____

If this information changes over the next year, please complete a new form.