



**PERMISSION
FOR TREATMENT
Faith Fest 2012
Augustana College
Sioux Falls, SD**

Participant's name _____ Sex _____

Date of birth _____ Age _____

Allergies/dietary restrictions _____

Activity limited by physician _____

Medication child is taking _____ Last tetanus shot _____

Primary physician _____ Phone _____

Medical insurance company _____ Policy number _____

[Attach a copy of your insurance card, front and back.]

Should an emergency occur, Augustana College should first attempt to contact me at these phone numbers:

Daytime _____ Evening _____

Should you be unable to contact me, please notify:

Name _____ Relationship _____ Phone _____

Name of church sponsoring your youth group _____

In case Augustana is unsuccessful in contacting me or my alternate, I hereby authorize medical authorities to perform or arrange for whatever treatment you may consider necessary for my child.

Parent/Guardian Name (Please print) _____

Signature _____ Date _____

Address _____ City/State/Zip _____