



COUDERSPORT  
ALLIANCE  
CHURCH

**Medical Slip**

I, \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_, hereinafter,  
*name of parent or guardian* *Name of Student*  
"My child," who was born on \_\_\_\_/\_\_\_\_/\_\_\_\_\_.

My child is attending and participating in activities of the Coudersport Alliance Church located at 1 Alliance Ave. in the borough of Coudersport, county of Potter, and state of Pennsylvania. I hereby authorize \_\_\_\_\_ who are 18 years of age or older, who supervise the activities at the Coudersport Alliance Church into whose are my child has been entrusted to consent to medial care or dental care, or both for my child.  
*Name of youth leader(s)*

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize \_\_\_\_\_ who are 18 years of age or older, who supervise the activities of the Coudersport Alliance Church upon completion of any treatment, and I specifically instruct any treatment health facility to surrender physical custody of my child to \_\_\_\_\_ who are 18 years of age or older who supervise the activities of the Coudersport Alliance Church.  
*Name of youth leader(s)* *Name of youth leader(s)*

It is understood that this authorization is given in advance of any special diagnosis, treatment or hospital care being required. But it is given to provide authority and power on the part of \_\_\_\_\_ and authorized designees, to exercise their best judgment on what is advisable for my child's care, upon the advise of such physician, dentist, and surgeon.  
*Name of youth leader(s)*

Dated \_\_\_\_/\_\_\_\_/\_\_\_\_\_.

Signature of parent or legal guardian \_\_\_\_\_

This document will be in effect until my child graduates from high school on or around date \_\_\_\_/\_\_\_\_/\_\_\_\_\_ or until my child's medical coverage changes.

**ADDITIONAL INFORMATION**

Student \_\_\_\_\_

Parent / Guardian \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Medical / Health Insurance Company \_\_\_\_\_

Insurance Policy Number \_\_\_\_\_

In case of emergency notify parent or guardian \_\_\_\_\_

Other emergency contact person \_\_\_\_\_ Phone \_\_\_\_\_

Allergies \_\_\_\_\_

Medicine being taken by my child \_\_\_\_\_

Please list any other comments or information about your child that a doctor should know.

Coudersport Alliance Church  
7 Alliance Ave  
Coudersport PA 16915  
814-274-8661