

Storm Student Ministry
AUTHORIZATION FOR MEDICAL TREATMENT DECISIONS

To Whom it May Concern:

I/We _____ residing at _____
_____, telephone number(____) _____, the parents and/or legal
guardians of _____, a minor child, hereby authorize The Summit and
its representatives or agents, with whom my/our minor child is attending camp/retreat, to make
any and all immediate medical care decisions related to the minor child while in their care and
custody. We further authorize any healthcare provider to administer any immediate medical
treatment related to the minor child.

Insurance company: _____

Plan number: _____

Telephone number: _____

Member name/number: _____

Personal care physician:

Name: _____

Address: _____

Phone number:(____) _____

Executed this ____ day of _____, 201_ at _____, TX.

Parent/Guardian

Parent/Guardian