SENDING OUT SERVANTS (SOS)
AUTHORIZATION FOR EMERGENCY MEDICAL CARE (for Minors)

I/We, the undersigned parent(s) or legal guardian of the minor Name_____do hereby authorize any necessary examination, anesthetic, dental, medical or surgical diagnosis or treatment by any duly licensed physician or dentist and hospital that may be deemed necessary and rendered to said minor under the guardian, specific consent of: _____(STM Leader who is temporary custodian), the temporary custodian of the said minor; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a licensed hospital. I/We authorize the physician or dentist to call in any necessary consultants at his/their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment. It is further understood that those persons who have temporary custody of said minor will attempt to talk with the parent(s)/legal guardian via telephone numbers listed below before treatment is rendered.

Consent for dates: _____to _____**If under the age of 18, parent/guardian must sign below.*

Parent/Guardian Signature of Applicant _____

Printed Name of Parent/Guardian of Applicant _____

Address _____

Daytime phone _____ Evening phone _____

Person(s) to be reached if parent/guardian cannot be contacted:

PLEASE PROVIDE THE FOLLOWING INFORMATION IN THE EVENT OF A MEDICAL EMERGENCY AND YOUR CHILD IS UNABLE TO SPEAK FOR THEMSELVES.

Date of Birth: _____ Blood type (if known)? _____
Personal Physician name: _____ Phone:_____

1. List all medications your child is currently taking including name, dose, and frequency. Use back of page if necessary.
2. Does your child have allergies to medications, food, pollen, insects, etc.?
   Circle Yes/ No If yes, please list. _____
3. Will your child be taking any medications (prescription or otherwise) while in the care of the above temporary custodian?_____ If so, what medications?_____
4. Does your child have any medical disorder of which a doctor should be aware?
   Circle Yes/No If YES, please use back of page to explain.
   Example: diabetes, hypoglycemia, high blood pressure, heart conditions, etc.
5. Any medical restrictions/disabilities that the team leader should be aware of?
   Circle Yes/No If yes, please use back of page to explain.
6. Have you consulted your health care provider regarding this trip? Circle Yes/ No

NOTARY ACKNOWLEDGEMENT

State of }County of }

BEFORE ME, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE, this the _____ day of _____A. D. 20 ____.
(L. S.)

My Commission Expires: _____ _____
Notary Public

IMMUNIZATION RECORD of minor [under 18 yrs of age]

Date	Vaccine	Dose	Physician/Clinic

AUTHORIZATION TO LEAVE THE COUNTRY
FOR MINOR (under 18)

I/We the undersigned parents or legal guardians of the minor listed below:

_____ _____
Minor's Name Birth Date

Have given permission to _____ (team leader) and other adults accompanying the team leader to take our young person out of the UNITED STATES into GUATEMALA during the dates of _____ to _____. The above minor is a member of the Sending Out Servants (SOS) Mission Group from Houston, Texas. Furthermore, while in GUATEMALA, we authorize the team leader and the other adults on the mission to seek the necessary medical care should our young person experience any illness or accident.

Dated this ____day of _____at _____(city and state).

Parent/Guardian Signature of Applicant _____

Printed Name of Parent/Guardian of Applicant _____

NOTARY ACKNOWLEDGEMENT

State of }

County of }
BEFORE ME, the undersigned authority, on this day personally appeared _____, known to me to be the person whose name subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE, this the _____ day of _____ A. D. 20 ____.
(L. S.)

My Commission Expires: _____ _____
Notary Public