AUTHORIZATION FOR EMERGENCY MEDICAL CARE/CONSENT

For the period: January 1, 2009 to January 31, 2010

I hereby authorize any staff person, sponsor, or parent representing **THE FIRST UNITED METHODIST CHURCH, INDEPENDENCE, KANSAS,** to approve treatment for my child, _____________________________________, whose date of birth is ________________ (Medical treatment may include diagnostic studies and interventions deemed necessary or advisable by the licensed physician or hospital providing care to mychild.). I hereby grant permission to release any information requested for the completion of treatment or medical/surgical/accident claims for my son/daughter.

I understand that all events of the church will becloselysupervised and that some events will require transportation to/from the church in privately-owned, church-owned, or professionallylicensed vehicles, and, unless otherwise stated, I consent to the participation of my child in these events, including those involving physical activity. I further agree not to hold the sponsors, church, or Kansas East Conference responsible for any accident, injury, or illness that might occur to my son/daughter during these events.

I attest that all information provided is true to the best of my knowledge.

This authorization for emergency medical care/consent is to cover the period of time from January 1, 2008 to January 31, 2009.

____ ____________________

(Signature of parent/guardian) (Date)

STATE OF KANSAS)
) ss:
COUNTY OF MONTGOMERY)

BE IT REMEMBERED, that on this day_____ of ____________, 2008, before me, the undersigned, a Notary Public in and for the county and state aforesaid, came _________________________ ____________________ who is personally known to me to be the same person who executed the foregoing Authorization for Emergency Medical Care/Consent, and such person duly acknowledged the execution of the same as his/her free and voluntary act and deed.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and affixed my official seal the day and year last above written.

____

My Appointment expires: __________________. NOTARY PUBLIC

HEALTH INFORMATION

Youth's name ___________________________________ Date of Birth ________________

Parent/Guardian's name ____

Daytime phone number (620) _____________ Evening phone number (620) ___________ Cell phone (620) ______________ Alternate person/phone number for emergency

___________________________________ Physician's name

______________________________ Phone number __________________

Insurance carrier ____

Policy number _____________________ Expiration date __________________________

Verification requirements ____

(Include copy of your card or policy, if possible!!)

Date of last tetanus shot or booster ____

Previous major injuries/illnesses? Please explain. __________________________________

____

Restrictions on activities? _______None _____ Sports ______ Swimming ______ Hiking Other? Specify: ____ Restrictions on diet? Please explain: ____

____

Medications required? Give name, purpose, instructions for sponsors: __________________

____

Medications that should **NOT** be given? ____

____

Allergies: _____ Penicillin ____ Tetanus shots _____ Hay Fever

_____ Sulfa ____ Poison ivy _____ Insect stings Other?

Specify: ____ Other information? ____

____