

Parental Consent/Medical Treatment Form FUMC Apalachicola

All Youth Participating in **ANY EVENT** associated with FUMC Apalachicola must complete this form.

I, the undersigned parent or guardian of, a minor, do hereby authorize adult workers with the youth of the above named church to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. Further, as parent or guardian of the minor named, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.

Name of Youth _____ Date of Birth ___/___/_____

Social Security Number _____

School _____ Grade _____

Address: _____

City: _____ State: _____ Zip: _____

Youth E-mail _____

Primary Parent or Guardian: _____

Phone (H) _____ (W) _____ (C) _____

Parent's Email _____

If Parent or Guardian is not available please contact:

Name: _____ Relationship _____

Phone (H) (W) (C)

Dr. Name Phone _____

Insurance Company: Policy # _____

(Please attach a copy of both sides of insurance card)

Signature of Parent or Guardian _____

*** NOTARY SIGNATURE NOTARY STAMP**

This person appeared before me or was personally known to me presented a photo id

MEDICAL INFORMATION

Please list all current medications your child is taking:

Does your child have any medical or health problems?
(please describe)

Has this student had any chronic or recurring illness?
(please describe)

Does this student have any restrictions on participating in activities?
(please describe)

Does this youth have any of the following allergies?

- Penicillin Insect Bites Insect Stings
- Hay Fever Poison Ivy Poison Oak

Any Other Drugs (please describe)_____

Any Types of Food (please describe)_____

Does this youth have any of the following conditions?

- Asthma Seizures Nose Bleeds
- Diabetes Heart Murmur Difficulty Seeing
- Difficulty Hearing High Blood Pressure

Please indicate the date of this youth's last tetanus shot_____