

Authorization for Medical Treatment
First United Methodist Church Youth Ministry

Authorization

I, _____, am the parent or legal guardian of _____,
Name of parent or guardian Name of minor
hereinafter, "my child", who was born on _____, _____. My child is attending and participating in activities at First United Methodist Church (hereinafter, "camp," "church," "school," etc.), located at 8650 West Sample Road in the city of Coral Springs, county of Broward, and the state of Florida, beginning on the day of December 15, 2008.

I hereby authorize the Pastor Terry Lee and his/her officers, agents, volunteers, or employees who are 18 years of age or older, who supervise the activities for this church into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child. 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 the Pastor Terry Lee and his/her officers, agents, volunteers, or employees who are 18 years of age or older, who supervise the activities the church to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to the pastor and his/her officers, agents, servants, or employees who are 18 years of age or older who supervise the activities at church.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and surgeon.

Dated _____, _____
Signature of parent or legal guardian

State of: Florida, County of Broward – Before me the undersigned, a Notary Public for the State of Florida, personally appeared _____ and acknowledged the execution of this instrument this _____ day of _____, 20_____

Signature of Notary Public

Printed or typed name of Notary Public

My Commission expires: _____, 20_____

Authorization for Medical Treatment

First United Methodist Church Youth Ministry

Medical Information

Student's name _____

Address _____

City _____

State _____

Zip _____

Home phone _____

Other phone _____

Emergency contact other than parent or guardian _____

Relationship to minor _____

Medical insurance company _____

Policy # _____

Mother's name _____

Home phone _____

Work Phone _____

Father's name _____

Home phone _____

Work phone _____

Physician _____

Office phone _____

Dentist _____

Office phone _____

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student a—
 good swimmer fair swimmer non-swimmer

2. Does your child have allergies to:
 pollens medications food insect bites

If so, what are they?

Medicines: _____

Foods: _____

Insect bites: _____

Medical History (cont'd)

3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:

- asthma epilepsy / seizure disorder heart trouble diabetes
 frequently upset stomach physical handicap?

4. Date of last tetanus shot: _____

5. Does your child wear glasses contact lenses hearing aid?

6. Please list and explain any major illnesses the child experienced during the last year:

7. Should this child's activities be restricted for any reason? Please explain:

8. What medicine is being taken by your child?

Additional medical history comments:

This form was researched and drafted by the law firm of
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