

**PARENTAL CONSENT AND MEDICAL AUTHORIZATION**

I, as the custodial parent (or legal guardian) of

\_\_\_\_\_ (Name of Child/Youth)

understand that my youth will be participating in a number of activities which carry with them a certain degree of risk. These activities may include, but are not limited to swimming, rafting, boating, hiking, camping, field trips, sports, skiing, rock climbing and other activities which the church may offer. My signature on the reverse side of this form constitutes my consent for my child to participate in these activities.

**Please indicate any restrictions on your child's / youth's activities:**

\_\_\_\_\_ I represent that my child/youth is physically fit and has the necessary skills to safely participate in all activities.

\_\_\_\_\_ I represent that my child/youth has the following physical restrictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I also give consent for my child/youth to travel to and from these events in transportation provided by staff and/or volunteer drivers.

**STUDENT INFORMATION**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Gender \_ Male \_ Female Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

**Emergency Contacts:**

(Name, Home Phone, Cell Phone/Pager)

Custodial parent or legal guardian?

1. \_\_\_\_\_ Yes \_\_\_ No \_\_\_

2. \_\_\_\_\_ Yes \_\_\_ No \_\_\_

3. \_\_\_\_\_ Yes \_\_\_ No \_\_\_

4. \_\_\_\_\_ Yes \_\_\_ No \_\_\_

**CHILD/YOUTH HEALTH AND MEDICAL INFORMATION & HEALTH HISTORY**

(Check and/or give approximate dates)

Chicken Pox \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Please describe your child's medical history including any current conditions under treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Glasses? \_\_\_\_\_ Contact Lens? \_\_\_\_\_

Please list all allergies:

\_\_\_\_\_

What treatment (if any) is required for Asthma?

\_\_\_\_\_

May your child self-administer treatment? \_\_\_\_\_

Does your child have any dietary modifications? No Yes (please attach specific information)

Current Medications:

\_\_\_\_\_

My Child is responsible for taking his/her own medication. \_\_\_\_\_

\_\_\_\_\_ I would like an adult representative to administer/oversee my child's medication. (please attach schedule)

Student's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Student's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Student's Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Please review the below list of over-the-counter medications (or generic equivalent) that may be available to youth group members. **If your child has allergies to any of the medications listed or if you feel any of the medications are inappropriate for your child, cross them off the list** - your child will not receive that medication.

Motrin (Ibuprofen) Midol Chloraseptic (throat spray) Tylenol

Immodium (anti-diarrhea) Tums/Maalox Betadine/Iodine (antiseptic) Sudafed

Cough Drops Benadryl Antibiotic ointment

\_\_\_\_\_ I give permission for my child to receive the above listed medications **except** those crossed out.

\_\_\_\_\_ I **do not** give permission for my child to receive the above listed medications.

In addition to the above, my child has permission to take the following medications:

\_\_\_\_\_

## MEDICAL AUTHORIZATION AND RELEASE OF LIABILITY

I have read and understand all sections of this form. I certify that the \_\_\_\_\_ is my child or legal ward and that I am legally authorized to execute this form. In the event that my child becomes ill or is injured or for any reason requires medical treatment while attending a South Shore United Methodist Church function or activity, I do hereby consent to any and all medical and/or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician(s) selected by agents or officials of South Shore United Methodist Church. In the event medical treatment is necessary, I hereby authorize any adult staff member of South Shore United Methodist Church or any other responsible adult accompanying the Church Ministry to give such consent for treatment and further agree to hold any person harmless from any liability, claims, demands, or suits of any nature arising from the giving of consent as long as the treatment is administered by or under the supervision of a licensed physician. The intention of this release is to grant authority to administer and perform any and all examinations, treatment, anesthetics, operations, and diagnostic procedures which may be deemed advisable or necessary by a qualified physician. I agree that payment for all charges incurred for medical examination and treatment is guaranteed by the parent/guardian or insurance company providing coverage for the above named student.

Medical/Health Insurance Company \_\_\_\_\_

Policy/Group Number \_\_\_\_\_ Phone Number \_\_\_\_\_

**PRIVACY PRACTICES**

I understand that by signing the South Shore United Methodist Church Health and Medical Information Release that representatives of South Shore United Methodist Church will be in possession of my minor child's medical information. I further understand that in the event of an emergency, I am giving permission for a South Shore United Methodist Church representative to provide the medical information contained on the Health and Medical Information Release to any and all health care providers selected by South Shore United Methodist Church representatives for the purpose of providing necessary and appropriate medical care to my minor child.

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\_\_\_\_\_  
Parent Name (please print)

\_\_\_\_\_  
Student/Minor Name (please print)

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

SWORN AND SUBSCRIBED BEFORE ME THIS \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_ by \_\_\_\_\_, who is personally known to me or whose identity I have proved on the basis of \_\_\_\_\_

\_\_\_\_\_  
Notary Public State of Florida County of \_\_\_\_\_

Printed Name \_\_\_\_\_

My commission expires: