AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

We, the undersigned parent(s) or guardian(s) of _____, a minor, do hereby authorize adult workers with children of The Centenary, First-Centenary United Methodist Church, as agent(s) for the undersigned, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care for the above referenced child which is deemed advisable by a physician. Further, I give permission for the above referenced child to be transported in a private vehicle.

Date _____ Grade/School in Fall 2021_____

Home Address_____

City _____ State _____ Zip _____

Parent/guardian with legal custody to be contacted in case of an illness or injury:

Name _____ Relationship to child _____

Home Phone_____ Work Phone_____ Cell Phone _____

Email: _____

Second parent/guardian for emergency contact:

Name _____ Relationship to child _____

Home Phone_____ Work Phone_____ Cell Phone _____

Email: _____

Health Insurance Company _____

Policy # _____ Group #_____

Name of Policy Holder _____

Pre Authorization phone number if required _____

Other emergency contact(s):

Name _____ Telephone _____ Relationship _____

Name _____ Telephone _____ Relationship _____

* * * * * * * * * * * *

The above information is current and accurate to the best of my knowledge.

_____ _____

(Parent/Guardian Signature) (Date)

MEDICAL INFORMATION

Child's Date of Birth: _____ Physician's Name: _____

Physician's Phone No. : (_____)_____

Is child allergic to any medication? _____ If yes, please list _____
_____

Any Other Allergies? _____ If yes, please list:_____
_____

Does child carry an EPIPEN or other medication for allergies? _____
If yes, please list the medications and dosage instructions_____
_____

Does your child have asthma? _____ Does your child carry any medications for asthma? _____
If yes, please list the medications and dosage instructions: _____
_____

Are there any special health conditions we need to know about or need to take into consideration in obtaining medical care or planning programs for your child (i.e. epilepsy, diabetes, emotional or behavioral challenges, etc.). _____ No _____ Yes (please explain below)
_____

_____

Is your child currently on any medication? ____ If yes, please list medicine and dosage.

Date of last tetanus shot: _____

If any changes in the health of my child occur after the completion of this form, I will inform the Director of The Centenary in writing.

Signed _____ Date _____

* * * * * * * * * * * *

If my child is stung by a bee or other stinging insect I give the staff of The Centenary permission to give my child Children's BENADRYL Allergy liquid.

_____ _____
Parent/Guardian Signature Date

CHILDREN'S ACTIVITIES CONSENT

I (We) the undersigned parent(s) or guardian(s) of _____, (a minor) give our consent for him/her to participate in all activities of The Centenary, First-Centenary United Methodist Church. This consent extends to participation in activities held on church premises as well as those held in other locations.

_____ _____
Parent/Guardian Signature Date