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 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 in Fall 2021_____

Parent(s) or Guardian(s) _____

Street Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone _____

Email: _____

Health Insurance Company _____

Policy # _____Group #_____

Name of Policy Holder _____

Social Security No. of Policy Holder _____

Pre Authorization phone number if required_____

Other emergency contact(s):

Name _____ Telephone _____ Relationship _____

Name _____ Telephone _____ Relationship _____

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

STATE OF TENNESSEE
COUNTY OF HAMILTON

_____appeared before me, a Notary Public
(Parent/Guardian Signature)

of the State and County aforesaid.

WITNESS my hand and seal this _____ day of _____, 20_____.

_____
NOTARY PUBLIC

My Commission expires: _____

MEDICAL INFORMATION

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

Physician's Phone No.:(_____)_____

Allergic to any medication? _____ If yes, please list:_____

Other Allergies?_____ If yes, please list:_____
Does child carry an EPIPEN or other medication for allergies?_____

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 problems, 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 understand that I need to inform the Director of Inner City Ministry in writing.

Signed _____ Date _____

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

If my child is stung by a bee or other stinging insect I give the staff of Inner City Ministry 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 the Inner City Ministry Program of First-Centenary United Methodist Church. This consent extends to participation in activities held on the church premises as well as those held in other locations.

_____ _____
Parent/Guardian Signature Date