

**First UMC Youth Ministries**  
**MEDICAL AUTHORIZATION FORM**

Effective September 2009 – August 2010

**Form to be taken on all trips**

**I. Background Information**

Youth's Name \_\_\_\_\_ Email: \_\_\_\_\_  
(please print clearly)

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Parent(s) / Guardian(s) \_\_\_\_\_

Are there any physical, mental, emotional or chronic conditions which the adult advisors or medical professionals should be aware of? \_\_\_\_\_

Are there any prescribed medications your child is required to take? \_\_\_\_\_  
If so, type of medication: \_\_\_\_\_ dosage? \_\_\_\_\_ frequency? \_\_\_\_\_

List any allergies (medication, environmental or food): \_\_\_\_\_

Any past surgeries and/or complications? \_\_\_\_\_ If so, explain \_\_\_\_\_

Medical attention for my youth is covered under the following insurance policy:

Ins. Company Name \_\_\_\_\_ Policy # \_\_\_\_\_ Holder's Name \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone: \_\_\_\_\_

Specialists \_\_\_\_\_ Phone: \_\_\_\_\_

**II. Transportation**

I give permission for my child to ride in any vehicle designated by the adult in whose care that minor has been entrusted while attending and participating in activities sponsored by First United Methodist Church. If it becomes necessary for my youth to come home for any medical or disciplinary reason, I agree to provide transportation and do so at my own expense.

**III. Medical Authorization**

**If professional medical care is required, I may be contacted at one of the following phone numbers:**

**Home** \_\_\_\_\_ **Cell** \_\_\_\_\_ **Work** \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, medical treatment may be rendered to my child. I authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist 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 said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

**IV. Photo and Video Consent**

I give Permission for my child may be photographed or videotaped by Troy First United Methodist Church for use in displays for the sole use of the church.

I do not give permission for my child to be photographed or videotaped by Troy First United Methodist Church for use in displays for the sole use of the church.

**V. Agreement**

The information on this form is accurate and I agree to all conditions asked of me.

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

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_