

MHCUCC PARENTAL CONSENT AND EMERGENCY/MEDICAL AUTHORIZATION FORM

For all activities through August 31, 2019

Name: _____ M/F Birth Date ___/___/___

The purpose of this information is to enable us to contact parent(s)/guardian(s) to authorize the provisions of emergency medical treatment when students become ill or injured while under our church/youth fellowship authority. It also gives us permission to transport your child to church/youth group events. This information will be shared with staff and emergency care providers as needed. *Please note that children may not carry or administer their own medication with the exception of epi pens and rescue inhalers. All medication is to be held and administered by the responsible adults.*

I GIVE PERMISSION TO TRANSPORT MY CHILD TO CHURCH/YOUTH FELLOWSHIP EVENTS _____
Parent Signature

Home Address: _____
Street City Zip

Parents/Legal Guardian with whom child resides: _____

Parent (1) _____	Parent (2) _____
Phone (h) _____ phone (c) _____	phone (h) _____ Phone © _____

Non-custodial Parent: (May we contact? Yes ___ No ___)

Name _____ Address _____ Phone _____

List two people to whom we can release your ill or injured child in the event you cannot be reached.

Name _____	Name _____
Phone (H) _____ Phone (C) _____	Phone (H) _____ Phone (C) _____
Relationship _____	Relationship _____

Child's medical history....

Serious allergies _____ Reaction _____

Usual treatment _____

Medical Conditions _____ Current treatment _____

Current Medications _____

Non-prescription medications _____

Other conditions/concerns _____

Health Insurance Provider _____

Consent for Treatment: In the event reasonable attempt to contact me has been unsuccessful, I hereby give my consent for the administration of treatment deemed necessary by the preferred listed physician or dentist, or in the event the listed doctor/dentist is not available, by another licensed physician or dentist; and the transfer of my child/ward to any reasonable accessible hospital where further consent will be obtained before treatment.

Physician _____ Phone _____ Dentist _____ Phone _____

Parent/Guardian Signature _____ Relationship _____ Date _____

Non-Consent for Treatment: I do not give consent for emergency medical treatment of my child. In the event of illness/injury I wish the church to take the following actions: _____

Parent/Guardian Signature _____ Relationship _____ Date _____