

TUSKAWILLA UNITED METHODIST CHURCH YOUTH MINISTRIES
3925 RED BUG LAKE ROAD
CASSELBERRY, FLORIDA 32707

PARENTAL CONSENT AND MEDICAL AUTHORIZATION (ANNUAL FORM)

Name of child/ youth: _____ Date of birth: _____ Age: _____
(First) (Middle) (Last)

Address: _____ City: _____ Zip Code: _____

Daytime phone: _____ Cellular Phone: _____ Home phone: _____

As the parent (or legal guardian) of: _____ (child's/ youth's name), I understand and consent that my child will be participating in on-site and off-site Tuskawilla United Methodist Church ministry activities which carry with them a certain degree of risk. I represent that my child is physically fit and has the necessary skills to participate in these activities. I represent that my child has restrictions on the following particular activities: _____

(Please indicate above any restrictions on your child's/ youth's activities.)

I also understand and give consent for my child/ youth to travel to and from off-site events in transportation provided by adult volunteer drivers.

MEDICAL TREATMENT AUTHORIZATION

It is my understanding that the Church will attempt to notify me in case of a need for care in a medical emergency involving my child/ youth. **If my child is deemed to be in need of Cardio Pulmonary Resuscitation, I give my permission for rescue treatment by initialing here:** _____. If the church cannot reach me, then I authorize the church to seek medical treatment at the nearest facility, and I give my permission to the doctor and/or other health-care professionals to provide the medical services they may deem necessary. I will assume financial responsibility for any medical expenses so incurred.

I will notify the church if I feel there are any health considerations that would prevent my child/youth's participation in any church ministry sponsored activities.

Allergies or other health considerations: _____

Medical Insurance Company: _____ Policy # _____
(Please attach a copy of insurance card)

Group # _____ Child/youth's Social Security # _____

Date of last tetanus immunization: _____ Current medications being taken: _____

Child/youth's Primary Physician: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Emergency phone number(s): _____
(Other than those listed above.)

Notary signature: _____

Notary name: _____ (STAMP)

This person appeared before me and: _____ was personally known to me.
_____ presented photo for identification.

***** This release is effective from January 1, 2010 - January 1, 2011 *****