Parental Consent/Medical Treatment Form for 2013/2014 School Year
St. Luke's United Methodist Church

I, the undersigned parent or guardian of, a minor, do hereby authorize adult workers with the youth of the above named church to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon 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 at said hospital.

Further, as parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.

Name of Youth _____ Date of Birth _____

School _____ Grade _____

Address:_____

City:_____State:____Zip:_____

E-mail _____ @ _____ . _____

Social Security Number _____ Passport Number_____

Primary Parent or Guardian:_____

Phone (H)_____(W)_____(C) _____

Primary Care Physician Name:_____

Phone:_____ Address:_____

If Parent or Guardian is not available please contact:

Name:_____

Phone (H)_____(W)_____(C) _____

Insurance Company:_____ Policy # _____
(A copy of both sides of insurance card must be attached)

Policy Holder and Relationship to Child _____

Policy Holders Date of Birth _____

Signature of Parent or Guardian _____

*** NOTARY SIGNATURE _____ NOTARY STAMP**

DATE_____

This person appeared before me or was personally known to me _____ presented a photo id _____

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MEDICAL INFORMATION

Students Name:_____ Date of Birth_____

Please list all current medications your child is taking:

_____

_____

Does your child have any medical or health problems? (Please describe)

_____

_____

Has this student had any chronic or recurring illness? (Please describe)

_____

_____

Does this student have any restrictions on participating in activities? (Please describe)

_____

_____

Does this youth have any of the following allergies?

___ Penicillin ___ Insect Bites ___ Insect Stings

___ Hay Fever ___ Poison Ivy ___ Poison Oak

Any Other Drugs (please describe)_____

Any Types of Food (please describe)_____

Does this youth have any of the following conditions?

___ Asthma ___ Seizures ___ Nose Bleeds

___ Diabetes ___ Heart Murmur ___ Difficulty Seeing

___ Difficulty Hearing ___ High Blood Pressure

Please indicate the date of this youth's last tetanus shot_____