

Christ United Methodist Church *Out of Area Medical Authorization*

NOTE: This form requires a notarized signature and is required for all out of area trips that are more than 2 hours away from Christ Church.

Name _____ **Date** _____
(clearly print name of child or youth)

Does your child/youth have a history of the following? Please answer "yes" or "no" and, if "yes," provide details below.

Allergies _____	Headaches _____
Asthma _____	Heart Disease _____
Insect Sting Reaction _____	High Blood Pressure _____
Diabetes _____	Hypoglycemia _____
Epilepsy _____	Auditory Problems _____
Dizziness or Fainting _____	Visual Problems _____

Other _____

Details _____

Has your child/youth had any major surgeries, mental impairment, disabilities, or hospitalizations that might impact his/her ability to fully participate in activities? If yes, please describe briefly. _____

What was the date of your child/youth's last tetanus shot or booster? _____

Is your child/youth under a doctor's care for any reason? If yes, please describe briefly. _____

Is your child/youth currently taking any prescribed or over-the-counter medication? If yes, please describe briefly. _____

Is your child/youth capable of monitoring medication schedule him/herself? If no, please include detailed instructions for the adult counselor (attach a separate sheet or original prescription label if needed).

Is there any additional information about your child/youth's physical or emotional health, or any condition that has not been disclosed in this form, which you think is important for the counselors to know? If yes, please explain. All information will be kept strictly confidential. _____

Please list your physician's name, address and telephone number: _____

Please list your dentist's/orthodontist's name, address and telephone number: _____

Please list the name, address and telephone number of any/all specialists whose care your youth is under: _____

MEDICAL AUTHORIZATION:

In the event that reasonable attempts to reach me have been unsuccessful and reasonable attempts to reach my child's physician have been unsuccessful, I give my consent for the administration of any treatment deemed necessary by a licensed physician or doctor and the transfer of my child to any reasonably accessible hospital or health care facility.

This authorization does not cover any major surgery unless the medical opinions of two licensed physicians or doctors, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Signature of Parent or Guardian

Date

Signature of Participant

Date

Phone numbers to be attempted in case of an emergency (include relation to youth)

Name of Insurance Company, including group #'s and phone number (please include a photocopy of card)

******* Please Note – Notary Required *******

Sworn to before me a subscribed in my presence this _____ day of _____, 20__.

Notary Public: _____