First United Methodist Church of Cocoa Beach

3300 N. Atlantic Ave, Cocoa Beach, FL 32931 Office: 321-783-8991 www.fumccb.com

Medical Authorization Form

Effective One Year: _____ to _____

Please print in ink youth/children names.

Name: _____ Age _____ Birthday _____
LAST FIRST MIDDLE

Name: _____ Age _____ Birthday _____
LAST FIRST MIDDLE

Name: _____ Age _____ Birthday _____
LAST FIRST MIDDLE

Name: _____ Age _____ Birthday _____
LAST FIRST MIDDLE

Address _____ City _____

State _____ Zip _____ Phone _____ Cell _____

Medical insurance company _____ Policy # _____

Mother's name _____ Phone: Home _____ Cell _____

Father's name _____ Phone: Home _____ Cell _____

Emerg. contact _____ Phone: Home _____ Cell _____

Physician _____ Office phone _____

Dentist _____ Office phone _____

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student a—

❑good swimmer ❑fair swimmer ❑non-swimmer

2. Does your child have allergies to—

❑pollens ❑medications ❑food ❑insect bites

3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:

❑asthma ❑epilepsy / seizure disorder ❑heart trouble ❑diabetes

❑frequently upset stomach ❑physical handicap

4. Date of last tetanus shot: _____

5. Does your child wear ❑glasses ❑contact lenses

6. Please list and explain any major illnesses the child experienced during the last year:

Additional comments:

Should this child's activities be restricted for any reason? Please explain:

I understand that my child/youth will be participating in a number of activities for the calendar year_____. Some activities may include, but are not limited to: cookouts, boating, water skiing, swimming, basketball, roller skating, rollerblading, games in the park, soccer, broomball, ice skating, volleyball, softball, baseball, camping, downhill skiing, snowboarding, hiking, biking, concerts, Bible studies, golfing, miniature golf, hayrides, and other activities which the church may offer. I consent for my child/youth to participate in these activities. Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the church youth pastor prior to that event.

_____ has my permission to attend all youth activities

PRINT NAME OF STUDENT

sponsored by _____

NAME OF ORGANIZATION

("Church") from _____ to _____.

DATE DATE

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she has a medical emergency and requires the attention of a doctor or medical health- care professional, I/we consent to any medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the student ministries staff member.

Parent/guardian signature: _____ Date: _____

Notary Public _____ SEAL

Sworn to and subscribed before me this (date) _____

Personally known to me _____

Driver's License No. _____

My commission expires (date) _____