ARCHBOLD UNITED METHODIST STUDENT MINISTRIES

401 Ditto Street, Archbold, OH 43502 419-445-5566 / fax: 419-445-3999

PARENTAL CONSENT, CERTIFICATION, MEDICAL AUTHORIZATION

Parents and legal guardians of minor youth are asked to complete this form and return it to the church. The information requested is designed to assist the church in providing for the safety of minors during church-sponsored activities.

*****Please attach a photocopy of your insurance card (front and back) to this form.*****

Personal Information

Participant's Name ________________________________ Date of birth M/D/Y ____________________

Home Address ________________________________ Home Phone ____________________

City, State ZIP ________________________________ Social Security # ____________________

Email Address ________________________________ Fax ____________________

School ________________________________ Current Grade ____________ Gender: M F

Medical Information

(Please circle correct answer.)

Any current medical conditions or problems? Yes No If yes, please explain:

____

Is participant allergic to any type of medication? Yes No If yes, please explain:

____

Any allergies other than medical? Yes No If yes, please explain:

____

Currently taking prescribed medications? Yes No If yes, please explain:

____

Past medical history/injuries/hospitalization/surgery we should be aware of:

____

Does participant have (or has ever had) any of the following? (Circle and explain below)

seizure disorders	asthma	heart murmur
diabetes	hay fever	kidney disease
sleepwalking	incontinence	

____

____

Can participant swim? Yes No

Does participant have any physical handicap or illness which would prevent him/her from participating in normal rigorous activities? Yes No If yes, please explain:

____

For medical reasons, does participant require a special diet? Yes No If yes, please explain:

____

Date of last tetanus shot (must be within 10 years): ________________________________

Adult leaders at Archbold UMC have my permission to administer:

Ibuprofen (Advil) __________ Acetaminophen (Tylenol) __________ Other ____________________

at the discretion of the adult as deemed necessary to the participant during church events. **Please initial:** Yes _____ No ______

YOUTH
In the event that an emergency arises where treatment at a hospital, clinic or physician's office necessary, please contact the following: (Please PRINT the information below)

A) PHYSICIAN Name ______________________________ Phone ____________________

Address ____

B) DENTIST Name ______________________________ Phone ____________________

Address ____

C) HOSPITAL or CLINIC preferred ______________________________ Phone ____________

Address ____

D) PARENT/GUARDIAN

FATHER ______________________________ Home Phone ______________

Social Security # __________________________ Work Phone ______________

Address ______________________________ Cell Phone ______________

MOTHER ______________________________ Home Phone ______________

Social Security # __________________________ Work Phone ______________

Address ______________________________ Cell Phone ______________

E) PRIMARY INSURANCE COVERAGE Company Name ______________________________

Name of Insured __________________________ Company Phone ______________

Policy Number ____________________

In case of emergency in which parents cannot be reached, please call:

Name: ____________________ Relationship: ____________________ Day phone: ______________

Address: ____ Night phone: ______________

CAUTION: This is a release and medical treatment form. Read before signing.
Note: If any change occurs in the above information, notify the church immediately.

Consent and Certification
I, the undersigned, being a parent or legal guardian of the participant named above, do hereby consent to the participation of him/her in all the regularly scheduled activities of The Archbold United Methodist Church of Archbold, including field trips, mission trips, camps, swimming, boating, hiking, sporting events, and any other activities customarily associated with a church youth group. Further, I certify that he/she is physically fit and adequately trained to participate in such events, including swimming (except as noted above).

Medical Treatment Authorization
I understand that I will be notified in the case of a medical emergency involving my child. However, in the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill. I understand that the Church will not be responsible for medical expenses incurred, but that such expenses will be my responsibility as parent/guardian.
I hereby release the Church, its staff and volunteer counselors of any reliability in the event of accident or injury. I agree to notify the Church in the event of any health changes, which would restrict my child's participation in any youth activities. I also understand that the adult supervisors reserve the right to restrict my child from any activities that they do not feel is within the capabilities of my child.

X ____ Date: ____________________
(Signature of Parent/Guardian, Affiant)

Print name: ______________________________________