MEDICAL CONSENT FORM

I (We)____, Parent(s) of __________________________________, hereby give permission for said child to attend and participate in activities sponsored by the First United Methodist Church of Henderson, Texas, beginning on the 1st day of June 2016, and ending on the 31st day of May 2017.

I (We) authorize the adult(s) in whose care our said child has been entrusted to consent to such medical and surgical treatment as may be required for our said child upon the advice of and after consulting with a physician or dentist who is duly licensed and in good standing in the state or country where such treatment is required. Such treatment may include X-ray examination, anesthetic, and such other medically recognized medical or surgical examination and treatment and hospital care as may be required for said child, which examination, treatment, or hospital care shall be rendered to said child under the general or special supervision and on the advice of such physician or dentist. I (We) will be consulted by such adult or his designee, as soon as practicable in the circumstances to obtain my (our) consent (non-consent). Nothing concerning my (our) notification shall limit the power of such adult to consent to medical or surgical treatment until I (we) notify such medical or surgical personnel that we are resuming the care of said child.

I (We) shall be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for said child to return home due to medical reasons or otherwise, I (we) shall assume all transportation costs.

I (We) do give permission for my (our) said child to ride in any vehicle designated by the adult(s) in whose care the child has been entrusted while attending and participating in activities sponsored by First United Methodist Church, Henderson, Texas.

Health and Accident Insurance Information:

Insurance Company: ____

Policy Number: ___________________Insurance Company Phone: _____________________

Signed this _____ day of ______________, _______.

______________________________ ________________ __________________
Parent Signature Home Phone Work Phone

______________________________ ________________ __________________
Parent Signature Home Phone Work Phone

STUDENT HEALTH INFORMATION

STUDENT'S NAME:____

STUDENT'S CELL#:_________________________________ **GRADE:** ________________

ADDRESS: ____

____

PARENT(S) / GUARDIAN(S) FULL NAMES: ____

ADDRESS:____

HOME PHONE:____

WORK PHONE:__________________________ __________________________________

CELL PHONE:____________________________ __________________________________

A. Family Physician:______________________________ **PHONE:**___________________

B. Does this student take any medications routinely? Please list:

C. Does this student have any allergies or health conditions we should be aware of?

D. In case we are unable to contact you in an emergency, whom should we contact next?

NAME:____________________________________ **PHONE:**___________________

Relationship to student:____