PARENTAL MEDICAL AUTHORIZATION FORM

Participant Name: _____ Birth date: _____

Medical Release

I hereby authorize the Brunswick United Methodist Church Youth Group chaperones, hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical or dental care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act for my child.

Custody Release

I further authorize the Brunswick United Methodist Church Youth Group chaperones to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

_____ _____ _____

Signature of Parent or Legal Guardian **Printed name of Parent or Guardian** **Date**

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian(s)	Phone Numbers	Phone Type (Home, Mobile, etc.)
Name(s)		
Street Address		

City State Zip

Parent(s)/Guardian(s) Email address(es)

Youth Members Email address(es)

Other Emergency Contact(s)	Phone Numbers	Phone Type (Home, Mobile, etc.)

Name(s) Relationship to Participant

Health Care Information

Participant Name: _____

Physician	**Dentist**
Name	Name
Phone	Phone
Medical Insurance Company	Dental Insurance Company
Policy/Group Number	Policy/Group Number
Name of Policy Holder	Name of Policy Holder

Date of last tetanus shot: _____/_____/_____

Please list any allergies to drugs, foods, plants, insects, etc:

Please list any prescription medication to be taken by the participant (including what it is taken for, when it is to be taken, dosage information, and any special procedures):

Please list any non-prescription (over-the-counter) medication you do NOT want dispensed to your child:

Please list any additional information relevant to participating in BUMC Youth group activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or indications, etc.):