

Lynn Haven United Methodist Church
4501 Transmitter Rd
Panama City, FL 32404
850-265-5231

2010

Authorization for Medical Treatment

We, the undersigned, as the parents and/or guardians of _____ hereby consent to any and all emergency medical and surgical treatment, including anesthesia and surgical procedures, which may be deemed advisable by qualified physicians selected by agents or officials of Lynn Have United Methodist Church. The intention thereof is to grant authority to administer and to perform examinations, treatments, anesthesia, surgical procedures, and diagnostic procedures, which may now, or during the course of the patient's care be deemed advisable or necessary by qualified physicians.

MEDICAL INSURANCE COMPANY _____ POLICY # _____

CHILD'S ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE # _____ BIRTHDATE _____

PARENT OR GUARDIAN _____

WORK AND CELL PHONE # _____

EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

_____ PHONE # _____

Is your child allergic to any form of medication or anesthesia? YES ____ NO ____

If yes, describe: _____

Is your child presently under medical treatment/taking medication? YES ____ NO ____

If yes, describe: _____

Frequency of medication: _____

If child needs mediation while on a trip with the children's ministry, please talk to the director before each trip.

IN WITNESS of our consent and agreement with the matters stated above, we have subscribed our signatures below.

DATE: _____

Parent/Guardian Signature

DATE: _____

Parent/Guardian Signature

STATE OF FLORIDA, COUNTY OF _____

SUBSCRIBED and sworn to before me, a Notary Public, the _____ day of _____ 20____.
My commission expires: _____

NOTARY PUBLIC

AFFIX SEAL HERE: