

2009 Medical Authorization Form
CALVARY UNITED METHODIST YOUTH MINISTRIES

Youth Name: _____

Youth SS#: _____

This sheet will be kept throughout the year by the adult chaperones. These people have accepted the responsibility for the welfare of the youth during all youth group activities. Any illness or injury should be reported to one of them immediately.

As parent (or guardian) of the above named person, I do hereby authorize and empower the adult leaders of the Calvary United Methodist Youth Ministries, in the event of sickness or accident involving the above named to do all things necessary to secure immediate medical care, including but not limited to the following:

1. Engage the services of qualified personnel to render necessary and proper immediate medical attention including diagnostic procedures such as x-rays, blood test, etc.
2. Secure admittance to medical facilities deemed appropriate for medical care and treatment.
3. Consent to the providing of any medical services or treatments such as the administering of any drugs, anesthetic, or the understanding of any surgical procedures, which are deemed necessary in an emergency situation.
4. Make such financial obligations and commitments, which are required in order to accomplish the purposes of this instrument.

It is understood that any treatment (other than emergency) will have a telephone (or other acceptable means) of acknowledgment from parent or nearest kin.

Signature of Parent (Guardian)

Phone # of Parent (Guardian)

Address of Parents (Guardian)

Emergency Contact & Phone

Insurance Information
(Please provide a copy of your insurance card)

Company Name

Subscriber Name

Group #

Identification #

Medical information

Name of Physician

Address of Personal Physician

Phone # of Physician

(Health History On Back)

Health History

**Please check any of the following health problems which apply.
(Information is confidential.)**

- | | | |
|--------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> frequent sore throat | <input type="checkbox"/> sinus or hay fever |
| <input type="checkbox"/> Asthma or bronchitis | <input type="checkbox"/> fainting spells | <input type="checkbox"/> frequent upset stomach |
| <input type="checkbox"/> kidney trouble | <input type="checkbox"/> heart trouble | <input type="checkbox"/> convulsions |
| <input type="checkbox"/> sleep walking | <input type="checkbox"/> diabetes | <input type="checkbox"/> menstrual problems |
| <input type="checkbox"/> recent operations or injuries | <input type="checkbox"/> allergic reactions to: stings, penicillin, aspirin, other allergies. | |

Please list any physical problems or sickness, allergies, and medications this person may have. Be specific. Give symptoms, reactions, treatments, purpose and names of medications, time to be taken, dosage, how administered, by whom, etc.

Is there any other information we need to know about your son or daughter?