Dixon United Methodist Church
United Methodist Youth Ministry
2014-2015 Emergency Information and Authorization for Treatment of a Minor

(Dates effective: this release shall remain in effect until revoked in writing)

Minor covered by authorization:

Minor's Full Legal Name:_____

Date of Birth:_____

Mailing address:_____

City/State/ Zip:_____

Email address:_____

Home Phone:_____ Cell Phone: _____

Mother's name:_____

Mailing address if different:_____

City/State/Zip:_____

Email address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Father's name:_____

Mailing address if different:_____

City/State/Zip:_____

Email address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

(please see next page)

Emergency Information:

Emergency Contact: _____ Relationship:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Primary Physician: _____ Medical Plan #:_____

Address:_____

Business Phone:_____

Medical History:

Any special medical problems, emotional problems or allergies (including food allergies):_____

_____

_____

_____

_____

Date of last Tetanus:_____

Current medications:_____

_____

Do you wear contacts? YES [ ] NO [ ]

(please see next page)

We, the undersigned parent(s) of _____, a minor, do hereby authorize Reverend Catharine Morris and any other adult acting on behalf of the Dixon United Methodist Church as agent(s) for the undersigned, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s), especially in case of emergency, to give specific consent to any such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

Signature of Parent or Guardian _____Date _____