HIGH SCHOOL

Valid Sept. **2007** - Aug. **2008**

ANONA **UMC**
13233 Indian Rocks Road • Largo, Florida 33774
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PARENTAL CONSENT AND MEDICAL AUTHORIZATION

I, as the custodial parent (or legal guardian) of ____

Name of child/student

understand that my child/youth will be participating in a number of activities which carry with them a certain degree of risk. These activities may include, but are not limited to swimming, boating, hiking, camping, field trips, sports, skiing, rock climbing and other activities which the church may offer. My signature on the reverse side of this form constitutes my consent for my child to participate in these activities.

Please indicate any restrictions on your child's / youth's activities:

_________ I represent that my child / youth is physically fit and has the necessary skills to safely participate in all activities.

_________ I represent that my child / youth has the following physical restrictions: ______________________________

____

_________ _ I also give consent for my child / youth to travel to and from these events in transportation provided by staff and/or volunteer drivers.

STUDENT INFORMATION

Name: ____________________________________ Birth Date: ____________ Age __________

Gender Male Female Home Phone: __________________________

Home Address ____________________________ City _________________ Zip ________

Parent/Guardian: __________________ Daytime Phone: ___________ Evening Phone: ________

Emergency Contacts: Name Home Phone Cell Phone Custodial parent or legal guardian?

1.____ Yes No ____

2.____ Yes No ____

CHILD/YOUTH HEALTH AND MEDICAL INFORMATION & HEALTH HISTORY

(Check and/or give approximate dates)

Chicken Pox _____________ Mumps ______________ Measles _____________

Date of last tetanus shot:_________________ _____________

Please describe your child's medical history including any current conditions under treatment:

____

____

____

____ Glasses? Contact Lens? _____

Please list all allergies: ____

____

What treatment (if any) is required for Asthma? ______________________________________

________________________________May your child self-administer treatment?___________________

Does your child have any dietary modifications: No Yes (please attach specific information)

Current Medications: ____

____

My Child is responsible for taking his/her own medication.

I would like an adult representative to administer/oversee my child's medication. (please attach schedule)

Student's Physician: ____

Address: ____ Phone: ______________

Student's Dentist: ______________________________________ Phone: ______________

Student's Orthodontist: __________________________________ Phone: ______________

Please review the below list of over-the-counter medications (or generic equivalent) that may be available to your child. **If your child has allergies to any of the medications listed or if you feel any of the medications are inappropriate for your child, cross them off the list.** Your child will not receive that medication.

Motrin (Ibuprofen)	Midol	Chloraseptic (throat spray)	Tylenol
Immodium (anti-diarrhea)	Tums/Maalox	Betadine/Iodine (antiseptic)	Sudafed
Cough Drops	Benadryl	Antibiotic ointment	

_____ I give permission for my child to receive the above listed medications **except** those crossed out.

_____ I **do not** give permission for my child to receive the above listed medications.

In addition to the above, my child has permission to take the following medications:

____

MEDICAL AUTHORIZATION AND RELEASE OF LIABILITY

I have read and understand all sections of this form. I certify that ________________________________ is my child or legal ward and that I am legally authorized to execute this form. In the event that my child becomes ill or is injured or for any reason requires medical treatment while attending an Anona United Methodist Church function or activity, I do hereby consent to any and all medical and/or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician(s) selected by agents or officials of Anona United Methodist Church. In the event medical treatment is necessary, I hereby authorize any adult staff member of Anona United Methodist Church, or any other responsible adult accompanying the Church Ministry to give such consent for treatment and further agree to hold any person harmless from any liability, claims, demands or suits of any nature arising from the giving of consent as long as the treatment is administered by or under the supervision of a licensed physician. The intention of this release is to grant authority to administer and perform any and all examinations, treatment, anesthetics, operations and diagnostic procedures which may be deemed advisable or necessary by a qualified physician. I agree that payment for all charges incurred for medical examination and treatment is guaranteed by the parent/guardian or insurance company providing coverage for the above named student.

Medical/Health Insurance Company:____

PRIVACY PRACTICES

I understand that by signing the Anona United Methodist Church, Health and Medical Information Release that representatives of Anona United Methodist Church, will be in possession of my minor child's medical information. I further understand that in the event of an emergency, I am giving permission for Anona United Methodist Church, representative to provide the medical information contained on the Health and Medical Information Release to any and all health care providers selected by Anona United Methodist Church, representatives for the purpose of providing necessary and appropriate medical care to my minor child.

___________________________________ ___________________________________

Parent Name (please print) Student/Minor Name (please print)

___________________________________ ____________________

Parent / Guardian Signature Date

BELOW TO BE NOTARIZED

Notary Public State of Florida County of ____________________

SWORN AND SUBSCRIBED BEFORE ME THIS _________ day of _________________________, 200______

by _____________________________________, who is personally known to me or whose identity I have

(affiliation)

proved on the basis of ____

(Type of Identification & Identification Number)

Printed Name ________________________ Commission Expires:

(Notary Public)