BRECKSVILLE UNITED METHODIST YOUTH GROUP

**EMERGENCY MEDICAL AUTHORIZATION**
**AND PERMISSION FORM**

**NOTE TO PARENTS/GUARDIAN: CHILDREN/YOUTH CANNOT GO ANYWHERE WITH THE GROUP WITHOUT THE EMERGENCY MEDICAL AND PERMISSION FORMS COMPLETED, SIGNED AND TURNED INTO THE YOUTH DIRECTOR. THESE WILL BE KEPT ON FILE FOR THE SCHOOL YEAR (Sept. 1, 2017-August 31, 2018).**

Name_____ Phone(___)_____

Address_____

Birth Date_____ Grade_____

*Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under the church's authority when parents or guardians cannot be reached.*

Mother's Name_____Phone (____)_____

Father's Name_____Phone (____)_____

In case of an emergency and we are unable to contact parent's:

Name_____Phone (____)_____Relationship_____

**I hereby give consent for the following medical care providers and local hospital to be called:**

Doctor_____Phone(____)_____

Dentist_____Phone(____)_____

Hospital Preferred_____Emergency Phone(____)_____

Hospitalization Carrier Name_____Policy No._____

Any chronic illness_____

Drugs currently taken_____Frequency_____

Student is permitted to take Tylenol for headache? _____YES _____NO

Student is permitted to take_____For fever_____For cold or flu symptoms

Student subject to motion sickness? _____YES _____NO If Yes, what medication can be taken_____

*In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctor or, in the event the designated preferred doctor is not available, by another licensed physician, and (2) the transfer of the child to any hospital reasonably accessible.*

*This authorization does not cover major surgery unless the medical opinions of two other physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.*

Facts concerning the student's medical history and physical impairments to which a physician should be alerted:

_____
_____
_____

**My Child has permission to attend the following activity dates: September 1, 2016 – August 31, 2017.**
**Signature of**
**Parent/Guardian_____**

Permission for photography of my child and any subsequent use in newsletters or on the website. ____ Yes ____ No