

THE UNITED METHODIST CHURCH OF MACEDONIA

1280 East Aurora Rd.
Macedonia, Ohio 44056
330-467-3169

MEDICAL FORM

I give my permission for _____ to attend any UMYF functions during the year _____.

Date: _____ Parent's Signature _____ Relationship _____

Address: _____

The phone number where I may be reached in the event of an emergency:

Day phone #: _____ Evening phone: _____

If in the event of an emergency I cannot be reached, the following persons are authorized to act in my behalf:

_____ Phone #: _____

Address: _____ Relationship: _____

Family Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital: _____ Phone: _____

INSURANCE INFORMATION

Name/Address of insure: _____

Social Security # of insure: _____

Social Security # of insured: _____

Name of medical insurance: _____

Insurance Identification #: _____

Does your child have a medical I.D. card? _____

I give permission for _____ and / any of the adults overseeing the event, to handle any emergency First Aid that may be needed and if all attempts to contact me have been unsuccessful. I hereby give my consent for the administration of any treatment deemed necessary by a licensed physician or dentist. This authorization dose not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessary for such surgery, are obtained prior to the performance of such surgery.

Date: _____ Parent's Signature: _____

(Please notify us of any changes in medical insurance or health problems)

Please list any allergies your child may have:

Please List any medication your child may be taking and the instructions for the administration and care of these medications. (If needed, use the reverse side of this paper):

Date of last tetanus shot: _____

Date: _____ Parent's Signature: _____