Fairwood Community United Methodist Church
Youth Health Information and Consent for Emergency Care

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Last Name

Personal Information	School and Grade	Gender	Date of Birth
Name			Telephone Number
Address	City	State	Zip Code
Custodial Parent/Guardian			Work phone
Non-Custodial Parent/Guardian (if applicable)			Work phone

First Name

Allergies

Hay Fever ____ Penicillin ____ Sulfa ____ Bee Sting ____ Poison Ivy ____ Other (name) _____

FOOD ALLERGIES: (Specify) _____

If any of the above are Yes , please submit a statement of how the youth reacts, how he/she has been treated and with what medication.

Special Needs/Situations

If your Youth has any physical, emotional, or medical limitations, please inform us to help the leaders provide appropriate support

Medications

LIST ALL REGULAR MEDICATIONS AND PROPER DOSAGE. (Use other side if needed)

Immunizations

ARE IMMUNIZATIONS UP TO DATE? Yes____ No____ DATE OF LAST TETANUS :_____

DATE OF LAST PHYSICAL_____ BLOOD TYPE _____

Insurance Coverage	Group number	Membership number
Family Doctor		Telephone Number

Emergency Contact (other than above individuals)

Telephone number

Consent For Emergency Care

I UNDERSTAND THAT, IN THE EVENT OF ILLNESS OR INJURY TO MY CHILD, EVERY EFFORT WILL BE MADE TO CONTACT ME OR THE PERSON LISTED ABOVE. IF NEITHER OF US CAN BE CONTACTED:

I, _____the custodial parent/legal guardian of _____ authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment. This release will remain in effect until September 30, 2009 unless revoked in writing.

Parent/Guardian _____ Date _____

Witness _____ Date _____

Witness _____ Date _____