YOUTH NAME _____

(Please print) Last First Middle

Asbury UMC Youth Group : 2016 - 2017

EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under AUMCY authority, when parents or guardians cannot be reached. This information will be shared, as necessary, with other YG leaders and volunteers.

Date of Birth _____ Home Phone _____

School _____ Address _____

School Year _____ City _____

Grade _____ Zip _____

Parent or Guardian

Mother's Name _____ Daytime Phone _____ Cell _____

Father's Name _____ Daytime Phone _____ Cell _____

Emergency Contact 1 _____ Daytime Phone _____ Cell _____

Emergency Contact 2 _____ Daytime Phone _____ Cell _____

Emergency Contact 2 _____ Daytime Phone _____ Cell _____

It is extremely important that you provide **ANY** pertinent medical history or information about existing conditions that may affect your child while on YG trips.

Medical Information: _____

_____

Medications: _____

_____

Allergies: _____

_____

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Doctor_____ Phone _____

Dentist _____ Phone _____

Specialist _____ Phone _____

Local Hospital/ER Phone _____

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 doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; 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 licensed physicians or dentists, concurring in the necessity f or such surgery, are obtained prior to the performance of such surgery.

_____

Signature of Parent/Guardian Date

PART II: REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish YG leaders to take to following action:

_____

_____

_____

_____

_____

_____

_____

_____

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_____

Signature of Parent/Guardian Date