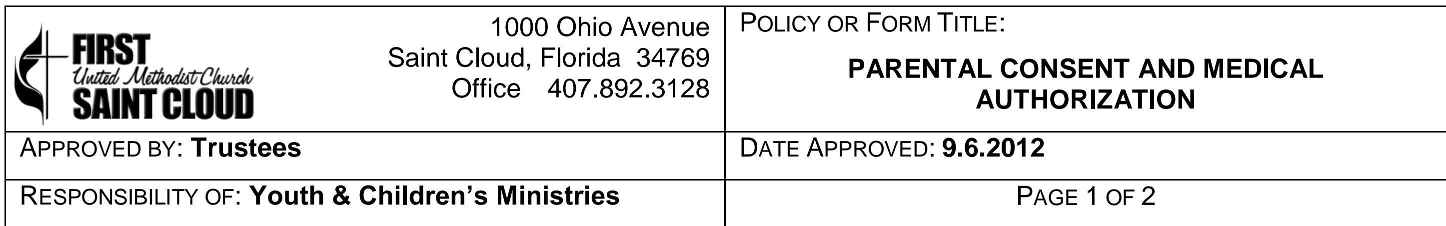

1000 Ohio Avenue Saint Cloud, Florida 34769 Office 407.892.3128	POLICY OR FORM TITLE: **PARENTAL CONSENT AND MEDICAL AUTHORIZATION**
APPROVED BY: **Trustees**	DATE APPROVED: **9.6.2012**
RESPONSIBILITY OF: **Youth & Children's Ministries**	PAGE 1 OF 2

PARENTAL CONSENT AND MEDICAL AUTHORIZATION

Name of child/youth:			
Date of Birth:		Current Grade:	
Address:			
City:		State & Zip Code:	
Home Phone:		Primary E-mail:	
1. ☐Mother or ☐Guardian __________:		Cell Phone (#1):	
2. ☐Father or ☐Guardian __________:		Cell Phone (#2):	

As the parent (or legal guardian) of: ____
Child/Youth's Name
by signing and notarizing this consent, I hereby release and discharge the First United Methodist Church of Saint Cloud, Florida (FUMCSC) from all liabilities, claims, and demands of whatever kind or nature that may arise or be connected with the child/youth's participation in as well as traveling to or returning from such activities. This consent releases the FUMC from the acts or omissions of its own agents or employees who have acted in good faith and to the best of their abilities. This consent does not release the FUMC from any liabilities, duties or responsibilities for the acts or omissions of its own agents or employees imposed by any laws, regulations or policies

I understand that my child/youth will be participating in a number of activities which carry with them a certain degree of risk. Some of the activities are swimming, boating, hiking, camping, field trips, sports and other activities which the FUMCSC may offer. I consent for my child/youth to participate in these activities.	**Initial**
I represent that my child/youth is physically fit and has the necessary skills to safely participate in these activities.	**Initial**
I represent that my child/youth has restrictions on the following particular activities. If none, state "None".	**Initial**
I will notify the FUMCSC if I feel there are any health considerations that would prevent my child/youth's participation in any of the activities listed above.	**Initial**
I also understand that if my child/youth becomes a discipline problem while on any trip, he/she will be sent home by the quickest means and at my expense.	**Initial**
I also understand and give consent for my child/youth to travel to and from these events in transportation provided by volunteer drivers.	**Initial**
MEDICAL TREATMENT AUTHORIZATION It is my understanding that the Church will attempt to notify me in care of a medical emergency involving my child/youth. If the church cannot reach me, then I authorize the church to hire a doctor or health-care professional, and I give my permission to the doctor or other health-care professional, to provide the medical services he or she may deem necessary while my child/youth is participating in FUMCSC activities in and out of Florida. Payment of all charges incurred for medical treatment is guaranteed by me or the insurance company providing coverage for my child	**Initial**

My child/youth has the following medical conditions. If none, state "None". Please also indicate current treatment for these medical conditions:	**Initial**
My child/youth is allergic to the following medications / foods / other. If none, state "None".	**Initial**
PERMISSION TO ADMINISTER MEDICATIONS I/we, the parent/guardian of above named child/youth, give my/our permission to the First United Methodist Church of Saint Cloud adult leaders to give the following medications (or the generic equivalents) to my/our child/youth, in accordance with the recommended package dosing for the specific indications below. ☐ Tylenol: Mild fever or discomforts ☐ Benadryl: Allergy symptoms ☐ Ibuprofen: Mild fever or discomforts ☐ Sudafed: Allergy Symptoms ☐ Throat Lozenges: Coughs/sore throat ☐ Antacid: Upset Stomach ☐ Topical Creams: Itching, sunburn, insect bites ☐ Anti-diarrheal: For diarrhea ☐ Permission to follow recommendations of local Poison Control Centers Other medications not listed:______________________________ ______________________________	☐ none **Initial**

Date of child/youth's last Tetanus injection (if known):	

☐ I do have medical insurance to cover treatment ☐ I do NOT have medical insurance to cover treatment				**Initial**
Insurance Company and phone number:				
Policy #:		Group #:		

EMERGENCY CONTACT INFORMATION

1st) Name:		Relationship	
Phone #a:		Phone #b:	
2nd) Name:		Relationship	
Phone #a:		Phone #b:	

This form is valid for one year from the date it is signed before a notary.

Signature of Parent / Guardian **WITNESSED** by a Notary Public	
Printed Name of Parent / Guardian	

Notary Public Stamp

On this _________ day of _____________________ , 20______ ,
before me, the undersigned Notary Public, personally appeared

____

who is personally known or proved to me through satisfactory evidence of identification,

which were ____ ,
to be the person whose name is signed on the proceeding or attached document and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of his/her knowledge and belief.

_____________________________ (County), State of ___________________________ ,

____ My Commission expires __________,
NOTARY PUBLIC SIGNATURE