2022-2023 YOUTH MEDICAL & TREATMENT CONSENT FORM

Valid July 1st, 2022 – June 30th, 2023

Youth name: _____

Insurance issued in the name of _____ Is coverage for dependents? _____

Medical/Health Insurance Co. Name: _____

Policy Number: _____ Group Number: _____

Preauthorization Phone # _____

TO WHOM IT MAY CONCERN:

I (we), the undersigned do hereby give permission for my (our) child, _____ to attend and participate in activities sponsored by Westland and Lebanon FUMC. I understand that activities, such as sports, field trips and other activities, carry with them a certain degree or risk. I release and discharge Westland and Lebanon FUMC and its representatives of all actions, claims and demands, whosoever which claimant now has or may hereafter have arising out of any accident, casualty and/or event which might happen while on the premises of Westland and Lebanon FUMC.

I (we) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision of any physician or dentist licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for my (our) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for his/her (their) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by Westland and Lebanon FUMC.

In addition, I also give authorization for Westland and Lebanon FUMC to use my child's first name, voice, likeness, photograph and video in program materials, promotional materials, and other works such as publications, video commercials and internet display.

SIGNATURE(S): ***Please sign in blue ink in front of Notary***

Parent/Legal Guardian: _____ Date: _____

NOTARY

Before me on _____(date), _____(parent/guardian), personally known to me or

who has produced _____ (Driv. Lic.#) as identification and who executed the forgoing instrument for the purpose therein expressed.

Notary Signature: _____ My commission expires: _____

STATE OF TENNESSEE)
COUNTY OF WILSON)

YOUTH MEDICAL INFORMATION

Youth's Full Name _____ Date of Birth _____

Social Security No. _____ F ☐ M ☐ Prefer Not to Say ☐ Grade 7☐ 8☐ 9☐ 10☐ 11☐ 12☐

Address _____

City/Zip_____ E-mail _____

Mother's name _____ Home Phone: _____
E-mail _____ Mobile Phone: _____
Work Phone: _____

Father's name _____ Home Phone: _____
E-mail _____ Mobile Phone: _____
Work Phone: _____

Emergency contact info:
Name/relation _____ Home Phone: _____
E-mail _____ Mobile Phone: _____
Work Phone: _____

Physician's name _____ Phone: _____

HEALTH HISTORY (Check all that apply)

Frequent ear infections ____
Frequent Colds/Sore Throats ____
Sinusitis/Bronchitis ____
Strep Throat ____
Mononucleosis ____
Heart Defect/Disease ____
Epilepsy/Seizures ____
Bleeding/Clotting Disorders ____
Hypertension ____
Stomach/GI Problems ____

DISEASES:
Chicken pox ____
Measles ____
Mumps ____
German Measles ____
Whooping Cough ____
Tuberculosis ____
Polio ____
Diabetes ____
Asthma ____
Arthritis ____

ALLERGIES:
Penicillin ____
Aspirin ____
Food: _____
Insect stings: _____
Plants: _____
Other: _____

SUBJECT TO:
Sleep Walking ____ Constipation _____
Fainting ____ Bedwetting _____
Other: _____

Other Conditions or Details of Above _____

_____

Are immunizations up to date? _____ If no, please explain _____
Date of last Tetanus Shot _____ Date of last TB test _____ Do you wear contacts? _____

Activity limitations? _____

Specific activities to be encouraged? _____

Specific activities to be restricted? _____

List any medications or drugs taken regularly _____

Special medical or dietary regime?

_____

_____