APPENDIX VI

Harvest United Methodist Church Child/Youth Guidelines

Parental Consent and Medical Authorization

Valid January 2019 through December 2019

Name of child/youth:________________________________Date of Birth:______Age:____

Address:____
Street/Apt Number City Zip code

School:____

Parent or Guardian: ____

Phone Number: (H)________________(W)_________________(C) __________________

E-mail: ____

If Parent or Guardian can not be reached please contact:

1. Name:_______________________________________Relationship:_________________

Phone Number: (H)________________(W)_________________(C) ____________________

2. Name:_______________________________________Relationship: ________________

Phone Number: (H)________________(W)_________________(C) ____________________

As the parent (or legal guardian) of: ____
Child/Youth's Name

I understand that my child/youth will be participating in a number of activities for the calendar year ________________, 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 church may offer. **I consent for my child to participate in these activities.______Yes ______No**

Please indicate any restrictions on your child's/youth/s activities:

_______I represent that my child/youth is physically fit and has the necessary skills to safely participate in these activities.

_______I represent that my child/youth has restrictions on the following particular activities:

_______I also understand and give consent for my child to travel to and from these events in transportation provided by volunteer drivers.

_______I give consent for my youth's photograph to be displayed on the Harvest web site or to be included in brochures related to the youth programming.

Medical Information

Please list all current medications your child is taking: ____

Does your child have any medical or health problems?: _______________________________________

Does your child have any of the following allergies?
_____Penicillin_____Insect Bites/Stings _____Hay Fever

Drug Allergies? (please describe) ____

Food Allergies? (please describe) ____

Does your child have any of the following conditions?

_____Asthma _____Seizures _____Nose Bleeds

_____Diabetes _____Heart Murmur _____Difficulty Seeing

_____Difficulty Hearing _____High Blood Pressure

Comments: ____

MEDICAL TREATMENT AUTHORIZATION
It is my understanding that the Church will attempt to notify me in case 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. I will pay for any medical expenses so incurred.
I will notify the church if I feel there are any health considerations that would prevent my child/youth's participation in any of the activities listed above.

Doctor's Name:_______________________________________Phone:________________________
Insurance Company:_________________________________Policy number: __________________

****Please attach a copy of both sides of your insurance card****

To Be Notarized

Signature of Parent or Guardian____

Sign in Presence of Notary

STATE OF FLORIDA

COUNTY OF ____________________

Sworn to or affirmed and subscribed before me this__________**day of**_______________,
by____.

Notary Signature: ______________________________________
Personally Known________________**OR Produced Identification**_________________
Type of Identification Produced ____
Notary Stamp/Seal