St. Francisville UMC Authorization for Medical Care

YOUTH INFORMATION
Name of Youth: ____
Date of Birth: ___/___/_____ Age: _____ Social Security Number: _________________
Address: ____
Home Phone Number: ________________ Cell Phone Number: ________________

PARENT(S)/GUARDIAN(S) INFORMATION
Father's Name: ____
Mailing Address (if different from Youth) ______________________________________
____
Social Security Number: ___________________________
Home Phone (if different from Youth) ______________________________
Place of Work: ____
Work Phone: ______________ Cell Phone: ______________
Mother's Name: __________
Mailing Address (if different from Youth) ______________________________________
____
Social Security Number: ___________________________
Home Phone (if different from Youth) ______________________________
Place of Work: ____
Work Phone: ______________ Cell Phone: ______________

ALTERNATE CONTACT INFORMATION
Name: ____
Relationship to Youth: ____
Address: ____
Home Phone: ______________ Work Phone: ______________ Cell Phone: _____________
****
Primary Physician: ____________________________________ Phone: ________________
Other Physician: ______________________________________ Phone: ________________
Specialty: ____
Dentist: ____________________________ Phone: ________________

Please Check All That Apply For Youth Listed Above:
_____ Allergies
_____ Asthma
_____ Cardiac
_____ Diabetes
_____ Nervous Disorder
_____ Epilepsy
_____ Physical Handicap
_____ Emotional Handicap
_____ Mental Handicap
_____ Seizure Disorder
_____ Other

If you have checked any of the above, please give details, including <u>all known allergies</u>:
____
____
____
Any restrictions that should be observed: ____
____
Date of last Tetanus shot: __________________
Medication(s) taken on a regular basis: ____
____

Rev. 08/2011

HEALTH INSURANCE INFORMATION

Health Insurance Group: ____

Group Number: _________________ Any Other Number Needed: ________________

Insurance Company Address: ____

Insurance Company Phone Number: _________________

Any Other Precertification Phone Number(s): __________________________________

A copy of the insurance card is attached.

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The undersigned Parent(s)/Guardian(s), hereby:

1. Certifies that the above information is true and correct
2. Agrees to update the above information with any changes, including providing a copy of any new insurance card received.
3. Waives any claim against St. Francisville United Methodist Church and its clergy, employees and volunteers.
4. Authorizes any Clergyperson, Staff Person, Adult Volunteer or Youth Counselor of St. Francisville United Methodist Church to take whatever steps may be necessary to obtain emergency medical care for the above listed youth, including, but not being limited to, the following:
    a. Attempting to contact parents or guardians through the numbers listed on this form
    b. Attempting to contact the youth's physician or dentist listed above.
    c. Transporting the youth to any doctor's or dentist's office, any medical facility, or any hospital, including calling an ambulance.
    d. Consenting to the treatment of the youth, including consent to any x-ray examination; anesthetic; medical, surgical or dental diagnosis or treatment; and hospital care to be rendered to the youth under the general or special supervision and on the advice of any physician or dentist. This consent includes the right to choose between alternative treatments. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being necessary, but it is given to provide my express authority to the representatives of St. Francisville United Methodist Church to give specific consent to any and all treatment that a provider may deem advisable in his/her professional judgment.
5. Gives permission to transport the youth home if necessary for medical reasons.
6. Agrees to pay any expenses incurred under numbers 3 or 4 above.
7. Agrees that St. Francisville United Methodist Church and/or its representatives will not be responsible for anything that may happen as a result of false information given on this form, or the failure to update this form.

____ ____/____/________

Signature(s) of Parent(s) Date

____ ____/____/________

Signature(s) of Parent(s) Date

Witness:____ ____/____/________

Signature Date

Please Remember to Include a Copy of Your **Health Insurance Card!**