

St. Paul's United Methodist Church
AUTHORIZATION TO CONSENT
FOR
TREATMENT OF A MINOR

I hereby grant to St. Paul's United Methodist Church staff or adult volunteers the authority to give an informed consent for the treatment of:

_____ (Child's Name) _____ (Age) _____ (Date of Birth)
should such child require medical care of any nature by reason of any condition or incident, except that the following procedures should not be performed without my consent unless the concurring medical opinion of two physicians is that such procedures are necessary to relieve the suffering or preserve the life or limb of such child and I cannot be reached after reasonable attempts:
a) Major Surgery
b) Other (if any)

MEDICAL HISTORY

Allergies to Medication _____
Allergies to Food _____
Last tetnus shot _____ Recent exposure to communicable disease _____
Past surgeries _____

PROVIDER INFORMATION

Our family physician is: Doctor _____
Phone _____
Our family dentist is: Doctor _____
Phone _____
Our hospital choice is _____
Health insurance plan Carrier _____
Group # _____
Member # _____

Please list any current medications here (use back if necessary)

Parent/Guardian Signature & Date _____

Address _____

Phone Numbers (please provide all) _____

Home Work Cell