Authorization for Medical Treatment

I, _____, am the parent or legal guardian of _____,
Name of parent or guardian Name of minor
hereinafter, “my child”, who was born on _____, _____. My child is attending and participating in activities at Gray United Methodist Church in the city of _____, county of _____, and state of _____, beginning on the day of _____.
I hereby authorize Bryan Orchard (Director of Student Ministries) and his/her officers, agents,

servants, or employees who are 18 years of age or older, who supervise the activities at Gray UMC into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child. The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize Bryan Orchard and his/her officers, agents, servants and employees who are 18 years of age or older, who supervise the activities at Gray UMC to receive physical custody of my child, upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to Bryan Orchard and his/her officers, agents, servants,or employees who are 18 years of age or older who supervise the activities at Gray UMC

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise his/her best judgment on what is advisable for my child’s care, upon advice of such physician, dentist, and surgeon.

Dated _____, _____ _____
Signature of parent or legal guardian

Additional information

_____
Parent / guardian

_____ _____ _____ _____
Address City State Zip

_____ _____
[Church Name]
[Contact Name and Phone #]

Student Data

Authorization for Medical Treatment

Home phone

Work phone

_____ _____

Medical / health insurance company

Insurance policy no.

_____ _____

In case of emergency, notify parent or guardian

Relationship to minor

_____

Allergies / allergic reaction of my child

_____

Medicine being taken by my child

_____

Other information regarding my child's health that a doctor should know

[Church Name]
[Contact Name and Phone #]