THE FIRST CONGREGATIONAL CHURCH

UNITED CHURCH OF CHRIST
444 East Broad Street ⁞ Columbus, Ohio 43215-3821 614-228-1741

Emergency Medical Authorization 2017 - 2018

Purpose - to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under First Congregational Church authority when parent/guardian cannot be reached. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are on the reverse side of this form.

Participant's Name: _____

Part I - To Grant Consent **(Part I or II must be completed)**

In the event reasonable attempts to contact me _____ (parent/guardian) at _____ (phone) or _____ (other parent/guardian) at _____ (phone) have been unsuccessful, I hereby give my consent for: (1) the administration deemed necessary to treat my child, _____(participant's name), by Dr. _____ (preferred physician) at _____ (phone) or Dr. _____ (preferred dentist) at _____ (phone) or, in the event the designated preferred practitioner is not available, by another licensed physician, or dentist, and (2) the transfer of the child to _____ (preferred hospital) or another hospital or any emergency treatment center reasonably accessible.

Date _____ Signature of Parent/Guardian _____

Part II - Refusal to Consent **(Do not complete Part II of you have completed Part I)**

I do not give my consent for emergency treatment of my child. In the event of illness or injury requiring treatment, I wish the First Congregational Church to take no action or to: _____

_____

Date _____ Signature of Parent/Guardian _____

Phone _____ Address _____

Health History 2017 - 2018

Participant's Name: _____ Home Phone: _____

Address: _____ Zip: _____

Parent's/Guardian's Names: _____

Work Phone(s) _____ Cell Phone(s)_____

Participant's Date of Birth: _____ Social Security No.: _____

Medical Insurance Carrier: _____ Policy or Group No.: _____

Illnesses and Injuries (check those that apply)

___ Ear Infections ___ Hypertension ___ Bladder/Kidney Disorder
___ Heart Defect/Disease ___ Seizures ___ Musculoskeletal Disorders
___ Bleeding/Clotting Disorder ___ Asthma ___ Diabetes
___ Other (specify) _____

Allergies (check those that apply and specific nature of allergic reaction)

___ Insect Stings _____ ___ Animals _____
___ Plants _____ ___ Pollen _____
___ Medicines/Drugs _____ ___ Hay Fever _____
___ Food _____ ___ Other (specify) _____

Other Health Conditions (check those that apply)

___ Bed wetting ___ Nosebleeds ___ Sleep disturbances
___ Constipation ___ Emotional Disorders ___ Fainting
___ Menstrual cramps ___ Hearing Impairment ___ Special dietary regimen
___ Motion sickness ___ Wears glasses or contact lenses ___ Headaches
___ Other (specify) _____

Are participant's immunizations up to date? _____ Date of last tetanus shot: _____

Medications currently being taken: _____
_____
_____

Explanations of above information or restrictions: _____
_____
_____

I know of no reason(s), other than the information indicated on this form, why my child should not participate in prescribed activities except as noted.

Signature of Parent/Guardian: _____ Date: _____