Coronado Community UMC
Parental Consent and Medical Authorization
To Be Completed by a Parent or Guardian and Notarized

Full Name: ____

Birth Date: _____/_____/______ Age: _______________ 2017-2018 Grade: _______________

Mailing Address: ____

City: ________________________________ State: ______ Zip Code: ____________________

Parent/Guardian Name: ____

Parent/Guardian Contact Info: Daytime ___________________ Evening ___________________

Cell _____________________ Email ____

As the parent or legal guardian of ____
I understand that my child will be participating in a number of activities for the period beginning September 1, 2017 and ending August 31, 2018 which carry with them a certain degree of risk. These activities include swimming, skiing, boating, hiking, camping, field trips, sports, and other activities which the church may offer. I consent for my child to participate in these activities, unless limitations are noted below. I agree that Coronado Community United Methodist Church, church personnel or volunteers will NOT be held responsible for accidents arising there from. I will notify the church if I feel there is any health condition that would prevent my child's participation in any of the activities offered by the church.

Please indicate any restrictions on your child's activities:

_____ I represent that my child is physically fit and has the necessary skills to safely participate in church activities.

_____ I represent that my child has the following restrictions on activities or health conditions:

Please initial: ________ I also understand and give consent for my child to travel to and from these events in transportation provided by licensed and approved drivers that meet the requirements of the CCUMC Child/Youth Protection Policy.

MEDICAL TREATMENT AUTHORIZATION

It is my understanding that Coronado Community United Methodist Church will attempt to

notify me in case of a medical emergency involving my child. 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/she may deem necessary. I will pay for any medical expenses so incurred.

If parent/guardian is not available in an emergency, notify: ______________________________

Phone: Daytime _________________ Evening _________________ Cell __________________

Relationship: ____

Allergies or other health considerations:

Allergies to Medications: ____

Food Allergies: ____

Other Allergies: ____

List any dietary restrictions: ____

Family Medical Insurance: _____ Yes _____No Insurance Company: ____________________

Group # ________________________ Policy #____

Name of Family Physician: ________________________ Phone: ________________________

____

Parent or Guardian Signature **Date**

____

Parent or Guardian Signature **Date**

TO BE COMPLETED BY A NOTARY PUBLIC

State of Florida, County of _________________________

The forgoing instrument was acknowledged before me this ______ day of ___________, 20____

By (print name) ___________________________ who is personally know to me, or has produced (type of identification) __________________________ as identification and did not take an oath.

Notary Public (signature): ____

My Commission Expires: _____________________________ (Notary Seal/Stamp)