OXFORD-UNIVERSITY
UNITED METHODIST CHURCH

AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR CHILD

_____ ☐ Male ☐ Female
Child's Full Name

_____ _____ /_____ /_____ _____ /_____ /_____
Age Birthday Month Day Year Date of Last Tetanus immunization

_____
Allergies

_____ _____
Family Doctor Phone Number

_____
Parent or Legal Guardian Full Name(s)

_____ _____ _____ _____
Address City State Zip

_____ _____
Father's Cell Phone Father's Work Phone

_____ _____
Mother's Cell Phone Mother's Work Phone

_____ _____
Insured's Place of Employment Phone Number

ENCLOSE A COPY OF YOUR INSURANCE CARD—FRONT AND BACK.

_____ _____
Insurance Company Name Group No.

_____ _____
Child's SSN Parent's SSN

_____ _____
Name of Responsible Person *(in absence of parents or legal guardian)* Contact Phone

_____ _____ _____ _____
Address City State Zip

I (WE) THE PARENTS OF THE CHILD NAMED BELOW HEREBY AUTHORIZE OXFORD-UNIVERSITY UNITED METHODIST CHURCH YOUTH STAFF OR ADULT LEADER TO CONSENT AND AGREE TO ANY MEDICAL, SURGICAL, OR DENTAL CARE OR TREATMENT BY ANY HOSPITAL, EMERGENCY CARE PROVIDER, PHYSICIAN OR DENTIST FOR:

_____
Child's Full Name

_____ _____
Parent(s) Signature Date