OXFORD-UNIVERSITY UNITED METHODIST CHURCH
OXFORD, MISSISSIPPI
AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR CHILD

Child's full name: _____

Age: _____ Birthday: _____ Male: ____ Female: ____

Allergies: _____

Tetanus (date of last immunization): _____

Medications taking now (note name, dosage, times taken): _____

_____

Family Doctor: _____ Phone Number: _____

Parents' or legal guardian full name(s): _____

_____

Address: _____

Father's home number: _____ Work: _____ Cell: _____

Mother's home number: _____ Work: _____ Cell: _____

Insured's Place of Employment: _____ Phone: _____

Enclose a copy of your insurance card ~ front and back.

Insurance Company Name: _____ Group No. _____

Child's SSN: _____ Parent SSN: _____

In absence of parents or legal guardian responsible person: _____

Telephone: _____ Address: _____

I (WE) THE PARENT(S) OF THE CHILDE 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 Name)

Dated this the _____ day of _____, _____.
Parent(s) Signature(s) _____