Providence United Methodist Church
2019-2020 Permission Form and Medical Agreement

Child's name_____
(last) (first) (prefer to be called)

Birthdate_____
(month/day/year)

Home address_____
(street) (city) (state) (zip code)

Home phone_____E-mail address_____

2019-20 School_____Grade in School_____

Are you a member of PUMC? _____If no, name of your church_____
*Your child's photo may be used (without names) in a newsletter or other social media, for Providence UMC. If you do NOT want your child's photo to be used, please initial here_____

IN CASE OF AN EMERGENCY CONTACT:

Parent(s)/Legal Guardian(s)_____
(circle one)

Day phone_____ Mobile phone_____

Evening phone_____E-mail_____

ALTERNATE CONTACT:

Name_____Daytime Phone_____

Evening Phone_____ Mobile Phone _____

Address_____Relationship to Youth_____
(street) (city/state) (zip)

MEDICAL INFORMATION

Doctor's name_____Phone_____

Dentist's name_____Phone_____

Date of last Tetanus Shot_____Medication(s) Youth may NOT take_____

Medication(s) child/youth will be taking during an activity with Providence UMC should be sent with Child/youth accompanied by written permission to administer (include dosage and time of day). Allergies and Special health concerns (i.e. special diet, disabilities) include:

_____

_____

please feel free to attach another page if necessary

PLEASE CONTINUE ON BACK…

Insurance Company_____Phone_____

Address_____
(street) (city) (state) (zip code)

Policy #_____Policy Holder's Identification #_____

Pharmacy Name_____

A NOTARY MUST BE PRESENT TO COMPLETE THIS SECTION.
DO NOT SIGN UNTIL IN THE PRESENCE OF A NOTARY.

In the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation in a Providence United Methodist Church activity, every reasonable effort will be made to contact the persons listed on the reverse side of this page. If unsuccessful in contacting the persons listed, consent/permission is given for treatment by competent medical personnel.

Further, and unless specified otherwise, consent/permission is hereby given to all accompanying adult paid or volunteer leaders on this activity to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery (under advisement of qualified medical personnel). Preference consideration should be given to those adults in attendance from my church.

I agree that my insurance company will be used for such medical care expenses, and I am aware that the medical provider for any medical treatment expenses not cover by my insurance may bill me. I understand that if I do not have medical insurance coverage that I am responsible for the payment of any medical bills.

_____
signature of parent or guardian relationship to youth

I, _____a Notary Public for the State of North Carolina in

_____ County, do hereby certify that

_____ personally appeared before me this day and acknowledged the due execution of the forgoing instrument.

Witness my hand and official seal this

_____day of _____ 2019 / 2020
(circle appropriate year)

_____
Notary Public, signature

_____
Notary Public, print

My Commission Expires_____