Stumptown Mennonite Church
Youth Ministries
EMERGENCY MEDICAL AUTHORIZATION

Student's Name_____ Male ___ Female ___ Date of Birth ___/___/___
Address _____
City _____ State ___ Zip _____ Phone _____
Name of Legal Guardian: _____
Name(s) of person with whom the student resides: _____
Permission to contact non-custodial parent _____ Phone _____
Known allergies: _____ Health Concerns (*asthma, diabetes, etc*) _____
Any known food allergies:_____ Current medications: _____
Name of insurance Company _____ Policy # _____

An authorization of the provision of emergency treatment for students who become ill or injured while involved in a Youth Ministry function. PLEASE LIST ONLY THE NAMES OF THOSE WHO HAVE AUTHORITY TO MAKE DECISIONS IN AN EMERGENCY SITUATION INVOLVING THIS STUDENT. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (ie 1st, 2nd, etc)

_____ Mother's Name _____ Home # _____ Cell # _____
Employment _____ Work # _____
_____ Father's Name _____ Home # _____ Cell #_____
Employment _____ Work # _____
_____ Other _____ Home # _____ Cell #_____
Relationship to Student_____ Work # _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) the administration of treatment deemed necessary by the preferred doctor indicated, or, in the event the designated, preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student to any reasonable accessible hospital. This authorization does not cover major surgery unless the medical options of two other licenses physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

PART 1 OR PART 2 MUST BE COMPLETED

Part 1: I hereby consent for the following medical care providers to be called:
Preferred Physician _____ Phone _____
Preferred Dentist _____ Phone _____
Preferred Hospital _____
Parent/Guardian Signature _____ Date Signed _____

Part 2: I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury, I wish Stumptown Mennonite Church to take the following action:

_____
Parent/Guardian Signature _____ Date Signed _____

CONFIRMATION OF INFORMATION:
School Year: September _____ through August _____ Grade _____ School _____
Above items are verified, reviewed & updated: *(parent initials)* _____ Date: _____

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