

# 280 NORTH MEDICAL AUTHORIZATION

I, \_\_\_\_\_, being the parent and/or legal guardian of

\_\_\_\_\_ authorize Winder First United

Methodist Church and designated chaperones to seek and obtain medical care for my child(ren) in

the event that my child(ren) need(s) medical care while participating in youth activities or trips

My child has the following allergies (if applicable): \_\_\_\_\_

If so, list prescribed medication(s): \_\_\_\_\_

My child has the following special medical condition or health concerns (if applicable):

\_\_\_\_\_

\_\_\_\_\_

If so, list prescribed medication(s): \_\_\_\_\_

I agree to be financially responsible for the cost of any medical care provided to my child(ren) under this Authorization.

Health insurance carrier \_\_\_\_\_

Policy or Certificate number \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Parent or Guardian Work Phone: \_\_\_\_\_

Parent or Guardian Mobile Phone: \_\_\_\_\_

Alternate contact name and phone number \_\_\_\_\_

Signature of Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_