

First United Methodist Church of Land O' Lakes,
6209 Land O' Lakes BLVD, Land O' Lakes, FL 34638

Comment [LDR1]:

2010 PARENTAL CONSENT AND MEDICAL AUTHORIZATION

Name of child/youth: _____ Grade: _____ Age: _____

Address: _____

Daytime Phone Number: _____ Evening Phone Number: _____

As the parent (or legal guardian) of: _____

Child/Youth's Name

I understand that my child/youth will be participating in a number of activities for the calendar year **2010**, which carry with them a certain degree of risk. Some of the activities are swimming, boating, hiking, camping, field trips, sports and other activities which the church may offer. I consent for my child to participate in these activities.

Please indicate any restrictions on your child's/youth/s activities:

_____ I represent that my child/youth is physically fit and has the necessary skills to safely participate in these activities.

_____ I represent that my child/youth has restrictions on the following particular activities: _____

_____ I also understand and give consent for my child to travel to and from these events in transportation provided by volunteer drivers.

MEDICAL TREATMENT AUTHORIZATION

It is my understanding that the Church will attempt to notify me in care of a medical emergency involving my child/youth. If the church cannot reach me, then I authorize the church to hire a doctor or health-care professional, and I give my permission to the doctor or other health-care professional, to provide the medical services he or she may deem necessary. I will pay for any medical expenses so incurred. I will notify the church if I feel there are any health considerations that would prevent my child/youth's participation in any of the activities listed above.

Insurance Company: _____ Policy/Group # _____

Signature of Parent or Guardian _____

STATE OF FLORIDA COUNTY OF _____
The foregoing instrument was acknowledged before me this _____ day of _____, _____, by _____.

Signature of Notary Public - State of Florida)

Print, Type, or Stamp Commissioned Name of Notary Public

Personally Known _____ OR Produced Identification _____

Type of Identification Produced: _____

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, you can add a page or write below with additional details.

1. For your child's safety and our knowledge, is your student a—
 good swimmer fair swimmer non-swimmer

2. Does your child have allergies to—
 pollens medications food insect bites

3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:
 asthma epilepsy / seizure disorder heart trouble diabetes
 frequently upset stomach physical handicap

4. Date of last tetanus shot: _____

5. Does your child wear glasses contact lenses

6. Please list and explain any major illnesses the child experienced during the last year:

7. Please list all medication, prescription or nonprescription, that your child is taking at this time:

8. List any over-the-counter medications (Aspirin, Midol, Tylenol, Advil, Etc) that your child **CAN NOT** be given:

9. List any medications that your child is allergic to:

10. List and other allergies other than medications that your child is allergic to:

11. List history of family diseases. Diabetes, heart, etc

12. Should this child's activities be restricted for any reason? Yes / No If yes Please explain:

13. Additional Details: