First Congregational Church UCC of Western Springs, Illinois
Plymouth Fellowship
PARENTAL MEDICAL AUTHORIZATION FORM

Participant Name: _____ **Birth date:** _____

I give permission for my child (named above) to attend the events, field trips, and service projects associated with the Plymouth Fellowship (PF) Youth Group of the First Congregational Church UCC of Western Springs, Illinois. I further give permission for my child to be transported to and from events by hired and volunteer drivers authorized by the First Congregational Church.

Medical Release

I hereby authorize the PF leaders, the First Congregational Church UCC of Western Springs Illinois, hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical or dental care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act for my child.

Custody Release

I further authorize the PF leaders of First Congregational Church UCC of Western Springs Illinois to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

Activity Release

I further give permission for my child to participate in all supervised activities except as noted:

_____ _____ _____
Signature of Parent or Legal Guardian **Printed name of Parent or Guardian** **Date**

EMERGENCY CONTACT INFORMATION

Parent(s)/Guardian(s)

_____
Name(s)

_____
Street Address

_____
City State Zip

Phone Numbers	Phone Type
	Mom cell
	Dad cell
	Home
	Home
	Other

_____
Parent(s)/Guardian(s) Email address(es)

_____
PFer Email address(es)

Other Emergency Contact(s)

_____
Name(s) Relationship to Participant

Phone Numbers	Phone Type (Home, Mobile, etc.)

Health Care Information

Participant Name: _____

Physician

Name

Phone

Medical Insurance Company

Policy/Group Number

Name of Policy Holder

Dentist

Name

Phone

Dental Insurance Company

Policy/Group Number

Name of Policy Holder

Please list any allergies to drugs, foods, plants, insects, etc:

Please list any prescription medication to be taken by the participant (including what it is taken for, when it is to be taken, dosage information, and any special procedures):

Please list any non-prescription (over-the-counter) medication you do NOT want dispensed to your child:

Please list any additional information relevant to participating in PF activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or conditions, etc.):

Are there any other situations or stressors (family, friends, school) in your child's life that the PF adult volunteers should be aware of?

Information provided on this form will be kept strictly confidential.