



# MEDICAL AUTHORIZATION AND PARENTAL CONSENT FORM

2022

PLEASE TYPE OR PRINT. USING INK ONLY!

*(This information must be completed, notarized and in the possession of event leader to attend)*

NAME OF CHILD: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ PARENT'S CELL PHONE: \_\_\_\_\_

**NAME OF YOUR AUTHORIZED REPRESENTATIVE, WE CAN REACH IN AN EMERGENCY, IF WE CANNOT REACH YOU:**

1. \_\_\_\_\_ PHONE: \_\_\_\_\_

2. \_\_\_\_\_ PHONE: \_\_\_\_\_

**PLEASE READ THE FOLLOWING MEDICAL AUTHORIZATION CAREFULLY BEFORE SIGNING.**

In the event that the above named child becomes ill or sustains injury while in this summer program or on any authorized and chaperoned outing from First Baptist Church, I, the undersigned, give my permission to those in charge to take whatever steps are necessary to stop any bleeding and to administer first aid.

I, also, consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the above named minor under the general or special supervision and on the advice of any duly licensed physician, surgeon, and/or dentist, whether such diagnosis or treatment is rendered at the office of said physician, surgeon, or dentist or at a licensed hospital.

The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for the aforementioned child to return home due to medical reasons, behavioral problems or otherwise, the undersigned agrees to assume all transportation costs.

The undersigned does also, hereby, give permission for the above named child to ride in any vehicle designated by the adult in whose care the minor has been entrusted, provided the child is in a safety belt and, if available, a shoulder strap while attending and participating in the activities sponsored by First Baptist Church.

HOSPITAL INSURANCE ? YES  NO  Physician \_\_\_\_\_ Phone \_\_\_\_\_

INSURANCE CO.: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

(Attach copy of Insurance Card)

**I. PLEASE INDICATE THE DATE YOUR CHILD LAST RECEIVED HIS/HER TETANUS IMMUNIZATION**

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

**II. LIST ANY ALLERGIES :**

FOOD \_\_\_\_\_

INSECT BITES/STINGS \_\_\_\_\_

PLANTS (poison ivy, oak ,sumac) \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

ANESTHESIA \_\_\_\_\_

OTHER \_\_\_\_\_

**III. LIST ANY PREVIOUS OPERATIONS OR SERIOUS ILLNESSES (please describe):**

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**IV. LIST ANY MEDICATIONS WHICH YOUR CHILD IS CURRENTLY TAKING:**

	NAME OF MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN	DATE PRESCRIBED
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

**V. CHILDHOOD DISEASES:** (check the ones your child has had)

- Chickenpox   
 Measles   
 Mumps   
 Whooping Cough  
 Other \_\_\_\_\_

**VI. CURRENT MEDICAL PROBLEMS**

- Asthma   
 Sinusitis   
 Bronchitis   
 Kidney Trouble   
 Heart Trouble   
 Diabetes  
 Dizziness   
 Stomach Upset   
 Hay Fever   
 Other \_\_\_\_\_

**VII. SPECIAL DIETARY REQUIREMENTS**

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I, the undersigned, do hereby give my permission for \_\_\_\_\_ to participate in the program and activities at First Baptist Church, Barnesville, GA. I, further, verify that the above information is correct and I do hereby release and forever discharge all sponsors, and First Baptist Church from any and all claims, demands, actions, or cause of action, past, present, or future arising out of any damage or injury while participating in the programs and activities of First Baptist Church. I, also, do hereby authorize the use of a photocopy of this instrument in lieu of the original.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ In the State of Georgia and the County of Lamar

Signature of parent or guardian \_\_\_\_\_

Relationship to above named minor \_\_\_\_\_

On this the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, personally appeared before me \_\_\_\_\_, personally known by me, and in my presence executed the within and foregoing Medical Authorization and Parental Consent Form.

Witness my hand and official seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires \_\_\_\_\_.