

### Emergency Treatment Consent Form

Effective Dates of this form: January 1—December 31, 2018

Child/Dependent's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Email of parent/guardian: \_\_\_\_\_  
Physician's Name \_\_\_\_\_ Physician's Phone number \_\_\_\_\_

#### Emergency Contact (if listed parent/guardian unavailable)

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to child \_\_\_\_\_ Work Phone \_\_\_\_\_

#### Health History

Special Medical Problems \_\_\_\_\_

Last Tetanus Shot (Td) (MM/DD/YY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Medications to be taken with directions: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

History of Asthma? Y N      History of seizures or other loss of consciousness? Y N

History of heart problems? Y N If yes, nature of problem: \_\_\_\_\_

May be given as necessary: Ibuprofen? Y N    Tylenol? Y N

Any specific activities: Encouraged: \_\_\_\_\_

Discouraged: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Subscriber \_\_\_\_\_

Group Number: \_\_\_\_\_ ID Number \_\_\_\_\_

"I hereby give my consent in advance to the designated youth leaders of Pendleton Center United Methodist Church on this trip, or other activity, and to the physicians or hospital selected by them, to render emergency treatment as in their judgment is reasonably necessary, including, but not limited to, hospitalization, diagnosis including taking specimens and x-rays, giving blood transfusions and medications, anesthesia and surgery for my dependent listed above. I understand that the leaders of this activity will attempt to contact me before securing medical treatment, but that this consent is given in case I am not available in an emergency.

I specifically release the leadership of this activity from any and all claims, loss, cost, damage or expense arising out of or from any accident or other occurrences causing injury to any person or property."

\_\_\_\_\_  
Signature of Parent/Guardian      Date

\_\_\_\_\_  
Signature of non-related adult witness      Date

**\*\*Attached is a copy of Health Insurance Card**