GREEN VALLEY METHODIST CHURCH

2200 Robindale Road
Henderson, NV 89074 - (702) 454-7989

2008 FIELD TRIP PERMISSION and
EMERGENCY MEDICAL TREATMENT INFORMATION for adults

Emergency Contact and Medical Information for a child or youth

NAME______________________PHONE (___)___________GRADE____AGE______

ADDRESS___________________________CITY_________________STATE_____ZIP________

DATE OF BIRTH____/___/___   M or F

I, the undersigned named child/youth do hereby authorize the staff, youth leaders or drivers acting on behalf of **Green Valley Methodist Church** with full power of attorney to act in the place and stead of the undersigned, during the period of **JANUARY 1, 2008 – DECEMBER 31, 2008,** with full powers to make any and all decisions, to authorize any and all emergency medical or dental treatment, surgery or hospitalization, which they along with the attending physician, deem necessary for the care and safety of the above named during the time of **regular local youth group/confirmation/hiking activities**. In no event will the Green Valley United Methodist Church, its officers, youth leaders, event coordinators, or agents be held liable for any first aid rendered, or treatments, drugs, medication or surgical procedures performed pursuant to this consent. In the event of any emergency, every effort will be made to contact the parent(s) or guardian(s) before any medical service is rendered aside from basic first aid. I take full responsibility for any financial cost which may be incurred for the care of my youth.

This power of attorney executed this _________day of_________, 200__.

NAME_____________________________________HOME PHONE_______________________

WORK PHONE______________________________CELL PHONE________________________

ADDRESS_______________________________CITY_____________STATE____ZIP_________

PARENT / GUARDIAN
SIGNATURE____DATE____________________

Permission is hereby granted for the following adults / participating during this year, who are members of our family.

_________________   ___________________   _________________   ______________________

The foregoing document was acknowledged before me, the undersigned Notary Public on this _________day of________________, 200_________.

My commission expires________________________

NOTARY PUBLIC
SIGNATURE________________________________

OVER

EMERGENCY CONTACT INFORMATION

Emergency Contact Person______________________________ Home Phone______________________

Address__________________________________ Work Phone __________Cell Phone______________

MEDICAL AND INSURANCE

Insurance Carrier_______________________ Policy Number_____________ Group Number__________

Insured's Name__________________ Insured's Social Security Number_________________________

Hospital / Clinic Preference______________________________Address_________________________

Physician's Name_______________________ Physician's Phone Number _____________________

Immunizations and date of last booster:

Measles________________________ Tetanus_________________________

Rubella________________________ Polio___________________________

Allergic reactions: _________Bee/wasp stings __________Penicillin
_________Foods _________ Medications

If any of the above are marked, please explain the reaction.

Additional information a doctor treating me should know.

I am currently taking the following medication:

NAME	MEDICATION	REASON	DIRECTIONS

Please list any activity restrictions or other needs.

________________________________ ________________________________
Signature Date

07/adult/permission