

GREEN VALLEY METHODIST CHURCH

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

2008 FIELD TRIP PERMISSION and EMERGENCY MEDICAL TREATMENT INFORMATION

Emergency Contact and Medical Information for a child or youth

YOUTH'S NAME _____ PHONE (____) _____ GRADE _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH ____/____/____ M or F

I/We, the undersigned parent(s)/guardian(s) of the above 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 child/youth 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__.

PARENT/GUARDIAN _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT / GUARDIAN

SIGNATURE _____ **DATE** _____

Permission is hereby granted for the following child / youth(s) 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.

My child / youth(s) is currently taking the following medication:

<u>NAME</u>	<u>MEDICATION</u>	<u>REASON</u>	<u>DIRECTIONS</u>
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Please list any emotional/behavioral/learning concerns.

Please list any activity restrictions or other needs.

While on youth group trips/activities, my youth(s) is allowed to drink coffee/tea _____yes _____no

Parent's signature

Date