

## Blanket Permission Slip Red Mountain UMYF 2009

\_\_\_\_\_ (Youth Name) has my permission to attend all official, off-campus, and pre-announced Red Mountain UMC Youth Program functions during the year. I will notify the church in writing of any exceptions to this blanket permission. It is understood that youth leaders will inform me of any changes to the off-campus activity schedule, and that my son or daughter will inform me whenever they will participate in an off-campus event. I am signing and submitting the notarized medical release below to Red Mountain United Methodist Church for the emergency medical treatment of my child.

- Red Mountain UMC may publish photos in print or online. If you do NOT want photos of your child/youth to be published, please check here ( )
- Are there custody issues you would like us to be aware of? If so, please describe:

*In the unlikely event your youth becomes ill or is injured during a church sponsored event, every attempt will be made to contact you. If for some reason we are unable to reach you or your emergency contact, this form will allow us to obtain emergency medical care for your youth. This is not a waiver of liability, but a means to help us ensure the best possible care for your youth until you can be reached.*

### CONSENT FOR MEDICAL TREATMENT AND SPECIAL POWER OF ATTORNEY

This Consent for Medical Treatment and Special Power of Attorney meets the needs as interpreted in current Arizona and Nevada law. Current law interpretation requires that the form be notarized and must be witnessed by a third party. This Consent for Medical Treatment and Special Power of Attorney is valid for SIX MONTHS. A photocopy or fax of this form has the same validation as the original.

Youth Participant Name: \_\_\_\_\_

The undersigned parent(s) or legal guardian(s) of the above-named Youth Participant do hereby appoint Red Mountain United Methodist Church (RMUMC) as attorney-in-fact with full power to act in the place and stead of the undersigned, in connection with any and all activities sponsored by RMUMC or any of its agencies in which the Youth Participant may be engaged, for the purpose of providing, authorizing, and making all decisions concerning medical treatment for the Youth Participant, including without limitation emergency medical care and safety of the Youth Participant during or in transit to or from the RMUMC sponsored activity. RMUMC may exercise this special power of attorney from time to time through any of its designated adult employees or agents and may demonstrate the existence of the authority granted hereby the presentation of either the original or photocopy of this Consent for Medical Treatment and Special Power of Attorney. The undersigned consent to all such medical treatment and take full responsibility for any financial cost, which may be incurred in connection with the medical treatment of the Youth Participant.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Parent(s)/Guardian(s) Signature(s) Home Phone

\_\_\_\_\_  
Address Alternate Phone

Subscribed and sworn before the undersigned notary public of the State of \_\_\_\_\_  
County of \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
My commission Expires: \_\_\_\_\_

Notary Public

**CHILDREN & YOUTH HEALTH FORM**  
For children, youth and volunteers under 18 years of age

PLEASE COMPLETE BOTH SIDES OF THIS FORM BY READING THE INSTRUCTIONS CAREFULLY. ALL INFORMATION IS VERY IMPORTANT TO INSURE THAT YOUR YOUTH HAS A POSITIVE EXPERIENCE. COMPLETE INFORMATION REGARDING MEDICATION IS NECESSARY.

⊕ Current weight is vital for correct medication in an emergency	⊕ Insurance information is important in case of an emergency
⊕ Be sure to note Seasonal Allergies and Allergic Reactions. If there are none, write "None"	⊕ Youth must have a closed toe and heel shoes for general wear
⊕ Medications must be noted or we will be unable to dispense medications to your youth	

Youth Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Hm Phone: \_\_\_\_\_ Wk/Cell Phone: \_\_\_\_\_

Residence Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

In an emergency notify (other than above) \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family Doctor in case detailed medical history is needed: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information:**

Insured's Name: \_\_\_\_\_ Emp ID # \_\_\_\_\_ Policy No: \_\_\_\_\_

Medical Insurance Co: \_\_\_\_\_ Group Subscriber's Name: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

Parent(s) or Guardian(s) will be notified of any emergency or unusual health care issue.

HEALTH HISTORY: Check --give dates		Date	Date	Date
Abcessed Ears		Constipation		Rheumatic Fever
Allergies (seasonal)		Diabetes		Scarlet Fever
Appendicitis		Diphtheria		Serious IVY, Sumac Poisoning
Asthma		Fainting		Sinusitis
Athlete's Foot		German Measles		Sleep Walking
Bed Wetting		Heart Trouble		Sore Throat (frequent)
Bronchitis		Kidney Trouble		Stomach Upset
Chickenpox		Measles		Tonsillitis
Colds (frequent)		Mumps		Tuberculosis
Convulsions or Epilepsy		Pneumonia		Whooping Cough
Operations or Serious Injuries:				
Emotional/Behavioral/Learning Concerns:				
<b>Immunizations and date of last Booster:</b>				
Measles	Tetanus	Hepatitis B	Polio	Rubella
<b>Allergic Reactions:</b>				
Bee Stings:	Aspirin	Other Drugs	Foods:	Other:
Penicillin	Tylenol			
<b>Medications – Over the Counter: If it is necessary to give medication to my child, I prefer: List Dose for appropriate for age.</b>				
Over the Counter Med	Dosage	Over the Counter Med	Dosage	Over The Counter Med
Tylenol		Antacids		Antihistamine (Name)
Nuprin/Advil				
<b>Medications - Prescribed</b>				
In order to provide the safest possible delivery of your youth's medication(s), please be sure that the medication(s) is/are labeled with the following: a) youth's name; b) Name and dose of drug; c) current directions for giving the medication, including time to be given and any special instruction (s) i.e. "give with food", etc. Sending Medications(s) in original containers with the above information is mandatory.				
Drug Name:	Dose	Direction (with food)		
Activity Restrictions:				
Heart/Other Handicap condition:				
Specify Special Needs:				
<b>Health Screening – This section to be completed by Camp Nurse at Campsite. Examination necessary only for a "YES" answer.</b>				
Sore Throat:	Ear Ache:	Rash:	Itchy Scalp/Lice:	Athlete's Foot:
Recent exposure to:	Measles:	Mumps:	Chicken Pox:	
Review of Medication(s) brought to camp:	YES NONE	Logged on routine Drug Form:	YES	
Ask: "Are you generally healthy now?"	YES NO			
Comments:				
Camp Nurse: _____ Date/Time: _____				

Legal Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_