

MEDICAL AUTHORIZATION FORM
Downtown United Presbyterian Church
Rochester, New York

I hereby grant authorization for my child/youth, _____, to participate in youth activities sponsored by the Downtown United Presbyterian Church until a written withdrawal of such authorization is delivered to the appropriate church staff.

I grant authorization for my child/youth to leave the church premises under the supervision of volunteer youth leaders or church staff.

I hereby grant authorization for any adult leader of the youth group or church staff to take whatever steps may be necessary to obtain such emergency medical care as may be deemed warranted. As soon as reasonable under the circumstances existing at the time, a youth leader or church staff person will take the following steps:

1. Attempt to contact parent or guardian listed below
2. Attempt to contact alternate person listed below
3. Attempt to contact child's/youth's physician listed below

If the designated parent or guardian, alternate contact person, or physician cannot be contacted after making a reasonable effort to do so under the circumstances existing at the time, a youth leader or church staff person is authorized to do one of the following, if such is deemed warranted by injuries or suspected injuries:

1. Call an ambulance
2. Have the child taken to the emergency hospital by one of the youth leaders, church staff, or other responsible person designated by any youth leader or church staff.
3. Allow on-site emergency medical aid to be administered by a licensed physician or emergency medical personnel serving the area where the aid is to be administered. Any expenses incurred in reasonable compliance with conditions set out above will be borne by the child's/youth's family.

Signature of parent/legal guardian Date Witness (other than spouse) Date

PARENT INFORMATION	Parent 1 or guardian	Parent 2 or guardian
Name	_____	_____
Address	_____	
Home Phone	_____	
Cell Phone	_____	
Employer	_____	
Work phone	_____	
Insurance Co.	_____	
Policy number	_____	

ALTERNATE CONTACT (other than above)

Name _____

Address _____

Home Phone _____ Cell phone _____

Employer _____ Work phone _____

MEDICAL INFORMATION

Youth Name _____

Birth date _____

Physician _____

Phone _____

Dentist _____

Phone _____

Date of Last Tetanus _____

Circle if there is a history with these medical conditions:

Hay fever

Cancer

Ulcers

Convulsions

Kidney problems

Fainting

Lung Problems/Asthma

Bee sting

Heart disease

Blood pressure problem

Diabetes

Other: _____

Current medications (Name, dose, time):

Known Allergies:

Past Surgery/Hospitalization (date/purpose) :

Illness: