

# Pleasant Green United Methodist Church Youth Ministries

3005 Pleasant Green Road

Durham, NC 27705

919-383-5467

Pleasantgreenumc.org

I/we, the undersigned, are the parents; the parents have legal custody, or the legal guardians of \_\_\_\_\_, a minor, and have given consent for him/her to participate in the Youth Ministry of Pleasant Green United Methodist Church. In the event that he/she is injured attending any event of this ministry and requires the attention of a doctor, I/we consent for such medical treatment and/or surgery to be given and performed to and upon my child as appears to be reasonably necessary in the exercise of prudent medical judgment of a licensed doctor of medicine (i.e. M.D.). In the event treatment is called for, which a physician and/or hospital personnel refuses to administer without my/our consent I/we hereby authorize \_\_\_\_\_ and/or other representative of Pleasant Green United Methodist Church to give such consent for us if I/we cannot be reached by telephone at one of the numbers below, or, because of emergency, there is not time or opportunity to make a telephone call and understand that I will be contacted as soon as possible. In the event it becomes necessary for that person to give consent for us, I/we agree to hold such person free and harmless of any claims, demands, or suits, for damages arising from giving such consent so as the treatment is administered by or under the supervision of a licensed physician. In this regard, it is understood that any medical, hospital and/or surgical expenses which may be incurred as a result of treatment recommended by any such a doctor will be borne by me/us. Further, I/we affirm that the health insurance information provided below is current and accurate.

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

\_\_\_\_\_  
PRINT NAME

## EMERGENCY INFORMATION

STUDENT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PARENTS NAME \_\_\_\_\_ TELEPHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELLPHONE \_\_\_\_\_

STUDENT DATE OF BIRTH \_\_\_\_\_

DOCTOR'S NAME \_\_\_\_\_ DOCTOR'S PHONE NUMBER \_\_\_\_\_

DENTIST'S NAME \_\_\_\_\_ DENTIST PHONE NUMBER \_\_\_\_\_

LIST OF ALLERGIES \_\_\_\_\_ LAST TETANUS SHOT \_\_\_\_\_

LIST OF ANY MEDICATION REQUIRED \_\_\_\_\_

LIST AND DESCRIBE ANY CHRONIC MEDICAL CONDITION OR HISTORY (ATTACH PAPER IF NECESSARY)

\_\_\_\_\_  
PERMISSION TO GIVE TYLENOL: YES/NO    ADVIL: YES/NO

HEALTH INSURANCE COVERAGE \_\_\_\_\_ POLICY NO. \_\_\_\_\_

PERSON TO CONTACT IN EMERGENCY IF PARENTS CANNOT BE REACHED

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_