St. Andrew's United Methodist Church
120 West Sandusky Street
Findlay OH 45840
419-422-4845

Authorization to Consent for Treatment of a Minor

I hereby grant **St. Andrew's UM Church staff or adult volunteers** the authority to give an informed consent for the treatment of:

_____
(Child's Name) (Age) (Date of Birth)

should such child require medical care of any nature by reason of any condition or incident, except that the following procedures should not be performed without my consent unless the concurring medical opinion of two physicians is that such procedures are necessary to relieve the suffering or preserve the life or limb of such child and I cannot be reached after reasonable attempts:

a) Major surgery _____ b) Other (please specify) _____

Facts concerning the **child's medical history, including allergies, physical impairments, last tetanus shot and medications being taken** to which a physician should be alerted are as follows:

Allergies: _____

Medications being taken, dose & purpose: _____

Medical Conditions/Physical Impairments: _____

_____ Date of last Tetanus shot: _____

Child's Physician: _____ Phone number: _____

Child's Dentist: _____ Phone number: _____

Preferred hospital: _____

Health Insurance Provider (if applicable): _____

Member # _____ Group # _____ **(Front/back copy of insurance card attached)**

Mother's Name: _____ Father's Name: _____

Custodial Parent (if applicable): _____

Mother's contact information:

_____
(Street address, City, State, Zip)

_____ _____
(Work phone) (Cell phone)

_____
(E-mail) (Home phone)

Father's contact information:

_____
(Street address, City, State, Zip)

_____ _____
(Work phone) (Cell phone)

_____
(E-mail) (Home phone)

Adult who may be contacted if neither parent can be reached:

_____ _____ _____ _____
(Name) (Relationship to Child) (Work or Home phone) (Cell phone)

I/We assume any and all costs of medical treatment that may be required.

_____ _____
(Signature of Parent/Guardian) (Date