



First United Methodist Church  
 300 W. Shotwell St. (39819)  
 P. O. Box 541 (39818)  
 Bainbridge, GA  
 Phone: (229) 246-1864 Fax: (229) 246-3800

**PARENT CONSENT FOR MEDICAL TREATMENT  
 BAINBRIDGE FUMC YOUTH/CHILDREN MINISTRY**

I the undersigned parent or guardian of \_\_\_\_\_, a minor, do hereby authorize adult workers with the Youth of the above named church to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is rendered under supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Further, as parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any Bainbridge FUMC Clergy, Staff, Representative of the Church, or other medical center for rendering such services.

**(Please completely print all the following information)**

Insurance Company or Group: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Name of Participant: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Parent Contact Number: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_

Primary Doctor Contact #: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication currently taking: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

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My signature confirms that I hereby give witness that this is the signature of the minor's parent or guardian and they are in fact who they say they have stated they are.

Signature of Notary: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

(Notary Seal)