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 TREATEMENT
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: ____

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)