

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
Temple Terrace United Methodist Church

Child's Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

Parent/Guardian 1: _____

Phones - Home: _____ Work: _____ Cell: _____

Parent/Guardian 2: _____

Phones - Home: _____ Work: _____ Cell: _____

Emergency Contact Person: _____

Relationship: _____ Phone: _____

Insurance (Please Provide Copy of Card) Company: _____

Contract/Group #: _____ Member # _____

Physician: _____ Phone: _____

Address: _____

Please list allergies. Include medication, food, and environmental. _____

Please list all medications taken. Include name, dosage, and when taken. _____

Please list medical conditions. _____

Blood type: _____

I hereby authorize representatives of Temple Terrace United Methodist Church (paid staff or volunteers) to seek emergency medical treatment for my child named above.

Dated this _____ day of _____, 20_____

Parent or Legal Guardian (Signature)

STATE OF FLORIDA

COUNTY OF HILLSBOUROUGH

_____ has sworn and subscribed before me and is personally known _____
or has produced identification _____ on this _____ day of _____, 20_____.

Notary Public _____