



2021-2022 Emergency Medical Authorization

Purpose – to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under First Congregational Church authority when parent/guardian cannot be reached. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of surgery, are obtained prior to the performance of such surgery. Facts concerning the child’s medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are on the reverse side of this form.

Participant’s name: _____

Part I or Part II must be completed.

Part I – To Grant Consent

In the event reasonable attempts to contact me _____
(parent/guardian)

at _____ or _____
(phone) (other parent/guardian)

at _____ have been unsuccessful, I hereby give my consent for
(phone)

1. The administration deemed necessary to treat my child, _____
(participant)

by Dr. _____ at _____
(preferred physician) (phone)

or Dr. _____ at _____
(preferred dentist) (phone)

or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist,

or, (2) the transfer of the child to _____
(preferred hospital)

or another hospital or any emergency treatment center reasonably accessible.

(Parent/Guardian) (date)

Part II – Refusal to Consent (Do not complete Part II if you have completed Part I above)

I do not give my consent for emergency treatment of my child. In the event of illness or injury requiring treatment, I request that First Congregational Church take no action or:

(Parent/Guardian) (date)

(address) (phone)



2021-2022 Health History

Participant's name: _____

(home phone) (address) (zip)

Parent's/Guardian's name(s): _____

(cell phone) (work phone) (email address)

(participant's date of birth) (Social Security no.) (participant's email address)

(medical insurance carrier) (policy or group no)

Illnesses and Injuries (check those that apply)

- Ear Infections Hypertension Seizures Asthma
- Diabetes Bladder/Kidney Disorder Bleeding/Clotting Disorder Heart Defect/Disease
- Musculoskeletal Disorders Other (specify) _____

Allergies (check those that apply and the specific nature of allergic reaction)

- Insect Stings Animals Plants Pollen Hay Fever

Medicines/Drugs (specify) _____ Food (specify) _____

Other (specify) _____

Other Health Conditions (check those that apply)

- Bed wetting Nosebleeds Sleep disturbances Constipation Fainting
- Hearing Impairment Emotional Disorders Headaches Motion sickness
- Wears glasses or contact lenses Menstrual cramps Special dietary regimen

Other (specify) _____

Are Participant's Immunizations Up to Date? Yes No Date of Last Tetanus Shot _____

List Current Medications _____

Additional Information or Restrictions _____

I know of no reason(s), other than the information indicated on this form, why my child should not participate in prescribed activities except as noted above.

(Parent/Guardian) (date)