Oak Grove United Methodist Church
1722 Oak Grove Road
Decatur, GA 30033
(404) 636-7558 - ext. 130

Medical and Permission Form

August 1, 2022 – August 31, 2023

Youth's Preferred Name: _____ Youth Cell phone: (____)_____

Address_____ City: _____ ST _____ Zip: _____

Date of Birth: _____

School: _____ Grade: _____ Gender: _____ Preferred Pronouns: _____

Parent/Guardian Name: _____ Email: _____

I, (we) the undersigned parents or guardians of _____, give permission for participation in the Youth Activities of Oak Grove United Methodist Church of Decatur, Georgia. With this form I release and discharge Oak Grove United Methodist Church, its authorized representatives and staff from liability of any kind. Furthermore, in the event of an accident or illness I hereby grant permission to said staff or representative to act as agents for me to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable. Permission is herby granted to administer first aid for minor problems.

Parent/Guardian Signature: _____

Bus. Tel. Father/Guardian: (___)_____ Bus. Tel. Mother/Guardian: (___)_____

Cell # Father/Guardian (___)_____ Cell # Mother/Guardian(___)_____

Insurance Co.: _____

Policy Number: _____

Certificate Number: _____ Group Number: _____

Other Number: _____ Name of Insured: _____

NOTARY: State of Georgia County of_____
Sworn to and scribed to before me this _____ day of _____, 20_____.

_____ _____
Signature My Commission expires

Seal

(PLEASE FILL OUT BACK PAGE)

Health Information Continued

Youth's Legal Name: _____ (DOB) _____

Operations: _____

Emotional Conditions (hyperventilation, hysteria, etc): _____

Medical Problems: _____

Allergies (specify any drug allergy OR food allergy): _____
Treatment if exposed: _____

Tetanus (date of last injection): _____

Present ongoing medical treatment: _____

Family Physician: _____ Phone: _____

Other Medical Conditions: _____
_____

General Health of Youth: _____

Emergency Contact Number Other Than Parent/Guardian: Name: _____

Phone: _____ Relationship to Youth: _____

Current Medication: _____
Will Youth administer own medication? Yes: _____ No: _____
Medication Instruction/Dose:
_____

_____