AUTHORIZATION FOR MEDICAL TREATMENT

_____ is the parent or legal guardian of: _____,

a minor, whose date of birth is _____ and whose social security number is _____-_____-_____.

I hereby consent to, and authorize, the rendering of medical care and treatment to my minor child in the event that such medical care and treatment becomes necessary. I agree to indemnify and hold harmless Clearbranch United Methodist Church, its staff, and Clearly Kid's staff from liability associated with the rendering of medical care and/or
treatment to my minor child where such medical treatment becomes necessary to protect the best interest of my child. Furthermore, I agree to be responsible for the payment of the reasonable charges related to the rendering of medical care to my minor child.

I, _____, parent, having a date of birth of _____ and a social security number of _____-_____-_____, authorize the disclosure of my child's personal health information to the representative from Clearbranch United Methodist Church Clearly Kid's staff in the event and to the extent that medical care and treatment become necessary while my child is attending Clearbranch United Methodist Church Children's Day Out or Kindergarten. I understand that this authorization is voluntary and is made to confirm my direction. I hereby give my permission to the following to disclose my child's health information to:
Clearbranch United Methodist Church Clearly Kid's staff.

The information to be disclosed to the staff in the event and to the extent that medical care or treatment of my child becomes necessary includes disclosure of his or her complete medical record, medical file including but not limited to doctors' and nurses' notes, x-ray reports, lab reports, history, physicals and all other such records of any type or nature necessary for the proper treatment of my child.

INSURANCE INFORMATION: **Please attach photocopy of insurance card**

Company_____Name of Insured_____Group / Contract #_____

My child is presently taking the following medications:_____

My child is allergic to the following medications:_____

My child suffers from the following medical conditions and/or allergies:_____

My child's Medical Physician is:_____ Phone_____

In the event of an emergency I can be reached at the following telephone numbers:

Home_____ Cell_____ Work / Other_____

In the event that I cannot be reached by telephone, please contact:

Name_____Relationship_____Home_____Cell_____

Name_____Relationship_____Home_____Cell_____

Name_____Relationship_____Home_____Cell_____

I understand it is my responsibility to update any of the above information as needed.

_____ _____ _____

(Date) (Printed Name of Parent or Legal Guardian) (Signature of Parent or Legal Guardian)

Address:_____City_____State_____Zip_____