

Parental Consent Form Discovery Program
Midway Locust Grove UMC

Child's Name	Age	Birth date
Address	(_____) _____	Phone
City	State	ZIP code
School	Grade in or just completed	
(_____) _____	(_____) _____	
Parent's work / business phones		

To whom it may concern:

The undersigned to hereby give permission for our (my) child, _____, to attend and participate in activities sponsored by **Midway Locust Grove United Methodist Church** for the Discovery After School Program.

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act of the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by **Midway Locust Grove United Methodist Church**. Additionally we (I) give permission for our (my) child's photo to be posted on the church's Web site or posted in the church or to us child's name for a prayer calendar or other ministry related published item.

Hospital insurance Yes No

Insurance Company _____

Policy number _____

Physician's name _____

Physician's phone _____

Emergency phone numbers in addition to the numbers listed above:

Name	phone number	Name	phone number
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Tetanus Shot Date _____. Please list any allergies or special medical problems your child may have on the back.
Thank you.