

# FOHL UMC YOUTH GROUP

## PARENTAL PERMISSION AUTHORIZATION FORM

**Event Name:** \_\_\_\_\_ **Place:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Participant Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

I give permission for my child to attend the Fohl UMC event listed above.

### **Medical Release**

I hereby request and authorize the Fohl UMC youth group, youth group leaders, hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical or dental care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act for my child.

\_\_\_\_\_  
**Signature of Parent or Legal Guardian**                      **Printed name of Parent or Guardian**                      **Date**

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Parent Home Phone #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

