

## MEDICAL FORM\*

(I) (We) the undersigned parent(s) or guardian(s) of \_\_\_\_\_, a minor, do hereby authorize adult workers with children of Fairfax United Methodist Church as agent(s) for the undersigned, to consent to any examination, X-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Signature \_\_\_\_\_ Date \_\_\_\_\_

My child's physician is \_\_\_\_\_ Phone \_\_\_\_\_

FULL name of child \_\_\_\_\_

Parent's Full Name (Name of Insured) \_\_\_\_\_

Full Address \_\_\_\_\_

Child's Birthday \_\_\_\_\_

Insured's Social Security Number \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Emergency Phone Number \_\_\_\_\_

School Child Attends \_\_\_\_\_ Grade \_\_\_\_\_

Please list any allergies, medications or medical history that is important in treating your child.  
Use the back of this form if necessary

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
\* In order to ensure the protection of your privacy and the accuracy of our records, please submit a new medical release form with each new trip or activity.