FIRST UNITED METHODIST CHURCH OF EVANSTON
JUNE 1, 2022 – AUGUST 31, 2023 MASTER MEDICAL FORM

FAMILY INFORMATION

Youth Name _____ **Age** _____
Last First Middle
Date of Birth: _____

Parent or Guardian _____ **Relationship** _____
Home Address _____
City, State, Zip Code _____
Cell Phone _____ **Home Phone** _____
Alternate Cell Phone _____ **Email** _____
Business/Employment Address _____
City, State, Zip Code _____ **Phone** _____
If above named parent or guardian is not available, please notify:
Name _____ **Phone** _____
Alternate Phone _____ **Email** _____
Relationship _____

CARE PROVIDER

Name of Family Physician _____ **Phone:** _____
Address _____
Medical/Hospital Insurance Carrier: _____
Address: _____ **Phone:** _____
Policy # _____ **Group No.** _____

ALLERGIES

The following information must be filled in by the parent/guardian. The intent of this information is to provide our youth staff with background to provide appropriate care. Any changes to this form should be given to us as updates are necessary. List all known allergies to food, medication, or other allergens. Describe reaction and management of the reaction.

_____

_____

_____

MEDICAL CONSENT FORM

Participant's Name _____

CERTIFICATION AND CONSENT TO AUTHORIZE MEDICAL CARE FOR MINOR:

I (Parent/Guardian Full Name) _____, **grant permission for my child to receive any emergency medical treatment and/or transportation for medical/hospital treatment while participating in Youth events, retreats, service projects, mission trips and other activities with First United Methodist Church, 516 Church Street, Evanston, IL 60201, 847/864-6181.**

_____ **Date:** _____
Parent/Guardian Signature