

### EMERGENCY TREATMENT

Youth's Name \_\_\_\_\_

In the event of an illness or accident, which requires immediate medical treatment at a time when a parent cannot be located, I give permission to the First United Methodist Church Leader or Staff, to authorize such treatment at the closest hospital to us. I will not hold First United Methodist Church or the medical personnel responsible. This is done with the understanding that every attempt will have been made to contact the parents, the child's physician, and other persons listed for emergency contact.

This responsibility does not extend to or include any eventual obligation, medical or monetary, as a result of the youth's illness or injury.

Date \_\_\_\_\_  
\_\_\_\_\_

Signed

Parent(s) or Legal Guardian

(s)

\_\_\_\_\_

Mom H \_\_\_\_\_ W \_\_\_\_\_

Address \_\_\_\_\_

Parents' Phone Numbers

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
\_\_\_\_\_

Dad H \_\_\_\_\_ W \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone \_\_\_\_\_  
Number \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ -

\_\_\_\_\_

Group Number \_\_\_\_\_ Identification  
Number \_\_\_\_\_