Rockledge United Methodist Church

AUTHORIZATION AND CONSENT TO TREAT MINOR

Name of minor: _____

Date of Birth: _____

The undersigned do hereby autorize the adult representative of Rockledge United Methodist Church, Rockledge Florida, or such substitute designed as agent for the undersigned to consent to any x-ray, examination, anesthetic, medical, dental, or surical diagnosis or treatment and hospital care for the above minor which is deemed advisable by, and to be rendered under, the general or special supervicion of any physician and surgeon, licensed under the Provision of Medicine Act or of any dentist licensed under the Dental practice Act, when said diagnosis or treatment is rendered at the office of said physician or dentist, at the hospital, or elsewhere.

This authorization will remain effective while the above minor is enroute to or from, or involved or participating in any childrens activity or mission trip activity of Rockledge United Methodist Church, unless revoked in writing by the undersigned, and delivered to the aforesaid agent.

FATHER / MOTHER OR GUARDIAN:

_____	_____	_____
Printed Name	Signature	Date

IN WITNESS WHEREOF, I have set my hand and seal on the date herein below shown:, SWORN and SUBSCRIBED before me on this _____ day of _____, 20__ at _____ Brevard County, Florida.

_____
Notary Public, State of Florida
My Commission Expires:

HOME ADDRESS: _____ HOME PHONE:_____

WORK PHONE: _____ CELL PHONE: _____

DOCTOR'S NAME:_____ DR'S PHONE: _____

INSURANCE CARRIER:_____ POLICY#: _____

IMPORTANT MEDICAL INFORMATION (ALLERGIES, MEDICATION, ETC.):

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