St. John's United Methodist Church
YOUTH MEDICAL CARE PERMISSION FORM 2017/2018
(For iServe only)

Name: (Last)______________________________(First)____________________________(M.I.)________
Date of Birth:___________________________ Parent's Cell:___________________________________
Parent's Name: (Last)______________________(First)____________________________(M.I.)________
Parent's Name: (Last)______________________(First)____________________________(M.I.)________
Name of Physician:___________________________________(Office Telephone)_____________________

I **do / do not** grant my child permission to ride on the St. John's bus with an approved driver.

I **do / do not** grant my child permission to ride in with an adult iServe volunteer in their personal vehicle.

MEDICAL HISTORY

No Yes Does this person have a current medical problem/condition? Describe:

No Yes Is this person allergic to any medications? Describe:

No Yes Is this person allergic to any foods or flavoring? Describe:

No Yes Does this person have Epilepsy or other nervous system disorder?
No Yes Does this person have Diabetes?
No Yes Does this person have asthma or other breathing problems?
No Yes Has this person had a tetanus shot within the last 7 years? Date:________________

Insurance Company:____
Group Number:____________________________________ Policy Number__________________________

THIS IS PERMISSION FOR THE TREATMENT OF MY CHILD BY A PHYSICIAN AND AT A HOSPITAL, OR BY A CHAPERONE FOR ANY MEDICAL OR SURGICAL EMERGENCY. Please note that the child will be taken to the nearest hospital. It may or may not be a participating HMO facility.

____ _______________________
Signature of parent or legal guardian Date

Print Name:_____________________________________