California-Nevada Annual Conference
The United Methodist Church
YOUTH MEDICAL HISTORY AND AUTHORIZATION

2010 Bishop's Confirmation

The following information is required to ensure that your youth's individual needs are met while part of the **2010 Bishop's Confirmation Retreat**. The information is confidential and will be made available only to those adults who are directly responsible for your child's care.

Name ______________________________ **Male** **Female** *(please circle)*

Home Address ______________________________

City ______________________________ **State** ________ **Zip** ______________

Birth Date ____________________ **Grade** ______________ **Home Phone (   )** ____________________

Father's Name ______________________________
Work Phone (   ) ____________________

Mother's Name ______________________________
Work Phone (   ) ____________________

If divorced, who has physical custody? ______________________________

If parents cannot be reached in an emergency, please contact:

Name ______________________________ **Relationship** ____________________

Home Phone (   ) ____________________ **Work Phone (   )** ____________________

Family Physician ______________________________ **Phone (   )** ____________________

Insurance Carrier/Plan Name ______________________________**Policy ID #** ____________________

Carrier Address ______________________________**City** ______________________________**St** ____________

Date of Last Tetanus shot ____________________ **Date of last physical examination** ____________________

Please list any allergies: ______________________________

Taking any medications: **Yes** **No** **Please list:** ______________________________

Is the participant under the direct care of a physician or is there any medical condition we need to be aware of? ____________

If yes, please explain: ______________________________

____

____

RELEASE STATEMENT

We, the undersigned(s) or legal guardian(s) of ____ , a minor, do hereby authorize the adult leaders acting on behalf of the California-Nevada Annual Conference of The United Methodist Church, as agent, and working with other non profit agencies or the City of Sacramento, 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 at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s), especially in case of emergency, to give specific consent to any such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his or her judgment may deem advisable. I agree to pay for any medical, dental, surgical, or hospital diagnosis, treatment, or care rendered to or for said minor.

____ ______________________
Signature Date