UNITED METHODIST TEMPLE
THE PLACE FOR KIDS

EMERGENCY MEDICAL AUTHORIZATION FORM

I, ______________________________, of ______________________________
(Parent/Guardian) (name of Child)

do hereby give my permission and/or consent for United Methodist Temple to secure and authorize such emergency medical care and/or treatment as my child, name above, might require while under the supervision of the said church. I also agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

PHYSICIAN TO CONTACT: ______________________ PHONE: _______________

HOSPITAL PREFERENCE: ____

IN CASE OF EMERGENCY, WHO MAY BE CALLED IF PARENTS CAN NOT BE REACHED?
(Local Residents Only)

Name	Phone	Relationship
______________________	______________	______________
______________________	______________	______________

DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS WE NEED TO KNOW?

Diabetes ________ Seizures ______ Emotional Problems _____

Defects in sight _____ Hearing ______ Speech ______

Allergies to Medicine ____

Other ____

IS YOUR CHILD ON ANY MEDICATION AT THIS TIME? Yes _____ No ____

Please explain: ____

SIGNED: ________________________________ DATE: ______________

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PICTURE AND VIDEO PERMISSION FORM

I, ______________________________________, **DO** give my permission for United Methodist
Parent/Guardian Name

Temple, Daycare and/or Preschool, to take and/or display pictures or videos of my child,

______________________________________, for use in the following ways:
Child's Name

___ bulletin board or other school displays

___ craft purposes

___ web page

___newspaper

___television

___video

___ audio

___special events

___social media

Signed: ______________________________________ Date: ____________________

CHILD HEALTH APPRAISAL

United Methodist Temple

DATE OF EXAM

The Place For Kids

Daycare **Preschool** School's Out / Summer Camp

CHILD'S NAME (Last, First, M.I.) | BIRTHDATE

CHILD'S ADDRESS (City/State/Zip) | TELEPHONE NUMBER

1. REVIEW OF HEALTH HISTORY

2. MEDICAL INFORMATION PERTINENT TO DIAGNOSIS AND TREATMENT IN CASE OF EMERGENCY.

3. SPECIAL INSTRUCTIONS TO PROVIDER REGARDING ANY MEDICATION REQUIRED DURING DAY CARE HOURS.

4. RECOMMENDED MODIFICATIONS OF LIMITATIONS OF CHILD'S ACTIVITIES OR DIET (i.e. allergies, etc.)

5. VISION
   ☐ Normal ☐ Abnormal

6. HEARING (auditory or equivalent)
   Subjective Screening (date)________
   Audiometry (date) __________

7.	MEDICAL				
	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Abdomen			Genitalia, Breasts		
Cardiovascular			Lungs		
Ears, Nose			Mouth, Throat		
Eyes			Skin, Lymph Nodes		
Extremities, Joints			Spine		

8. HGB
   ☐ Normal ☐ Abnormal

9. GM or HCT %
   ☐ Normal ☐ Abnormal

10. BLOOD PRESSURE
    ☐ Normal ☐ Abnormal

11. GROWTH MEASUREMENT

Height __________ Percentile _______ Weight ________ lbs. Percentile _________

12. DEVELOPMENTAL APPRAISAL

IS THE CHILD PROGRESSING NORMALLY WITH AGE OR GROUP? ☐ Yes ☐ No

NAME & ADDRESS OF PHYSICIAN

____
Physician's Signature

____
Date