Asbury United Methodist Church's
Children's Morning Out

Witnessed Emergency Consent

Child's Full Name _____

Date of Birth _____

This form allows parents and guardians to authorize the provision of emergency treatment for above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached. I agree to pay all costs and fees associated with the emergency medical and/or dental treatment for my child as authorized under this consent.

In the event reasonable attempts to contact me at the following numbers:

1. _____

2. _____

have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by Columbus Regional Hospital Emergency Room Physicians.

Date of Last Tetanus Shot: _____

Known Allergies: _____

Present Medication: _____

Signature of Parent(s) or Guardian _____
Date _____

Witness _____
Date _____