

**California-Nevada Annual Conference  
The United Methodist Church  
YOUTH MEDICAL HISTORY AND AUTHORIZATION  
2012 Bishop's Confirmation**

The following information is required to ensure that your youth's individual needs are met while part of the **2012 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
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? _____			
<i>If parents cannot be reached in an emergency, please contact:</i>			
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