Must be Notarized **FORM D**

MEDICAL EMERGENCY FORM

Name (of Child) ______________________________ Date of Birth ____________________
SS# __________________ Address ____

IN CASE OF AN EMERGENCY, NOTIFY:

Name ____ Relationship; ______ Parent _______ Other

Address ____________________________________ City __________________________________

State ___________ Zip Code __________ Telephone Numbers: Home: (___) ______________

Work: (___) ______________ Cell: (___) _________________

ALLERGIES (Please write YES if applicable)

Hay fever ________ Asthma __________ Sulfa ___________ Poison Ivy __________
Penicillin _________ Bee Sting _________ Other ____________________________

PLEASE CHECK IF INDIVIDUAL/CHILD HAS ANY OF THE FOLLOWING CONDITIONS:

Diabetes ________ Convulsions ______ Bleeding Disorders ______ Contact Lenses ______ Fainting Spells _____
Heart Trouble _______ Prosthesis _________ Migraine Headaches _____

If any of the above items are YES, please submit statement of how the individual/child has been treated and with what medications.

PLEASE CHECK APPROPRIATE RESPONSE:

YES ______ NO ________ I/My child can be given aspirin or Tylenol if needed for minor pain.
YES ______ NO ________ I/MY child have/has a medical condition. If **yes**, please describe;
YES ______ NO ________ I/My child am/is taking medication. If so, please list name, dosage and medical condition: ______________________________
YES ______ NO ________ Treatment received for any illness/injury within the last year?

If yes, please explain: ____

In case of emergency, I understand that no effort may be made to contact parents or guardian prior to emergency treatment. I hereby give permission to any physician, hospital and/or health care personnel to secure proper treatment for hospitalize, and to order injections, medication, anesthesia, surgery or other necessary treatment for my child named above. I also give permission to secure proper emergency medical transportation.

HEALTH INSURANCE CO. ______________________________ POLICY NO. ______________________
FAMILY PHYSICIAN __________________________ FAMILY PHYSICIAN TELEPHONE __________________
____ DATE: _________________________
(Signature of Parent/Guardian)

STATE OF ___________________ COUNTY OF ___________________

The foregoing was acknowledged before me this ______ day of ______________, _________.

My Commission Expires: ______________________________ Notary Public ______________________

Must be Notarized Form E

LIMITED POWER OF ATTORNEY FOR HEATH CARE

That I, ______________________________, a resident of ________________ County, ________________, as parent and/or legal guardian of ____________________ (hereinafter "my minor child"), do hereby make, constitute and appoint ________________________________ and ________________________________ of ________________ County, Kentucky, as my true

(youth minister)

true and lawful attorney in fact (hereinafter "my attorney"), for myself and my minor child and in my name, place and stead, in my attorney's sole discretion, to make any and all health care decisions relating to my minor child while in the custody of my attorney. I give permission to my attorney to make decisions relating to any necessary medical treatment including but not limited to hospitalization, surgery, administration of medications, anesthesia or injections, for my minor child while in the custody of my attorney.

This instrument is intended to, and does hereby, grant to my attorney full power and authority to do and perform each and every act and thing whatsoever requisite, necessary, and proper to be done, in the exercise of any of the rights and powers herein granted as fully, to all intents and purposes, as I might or could do if personally present, and I hereby ratify and confirm all that my attorney shall do or cause to be done by virtue thereof.

I, on behalf of myself, my minor child and our heirs, assigns, executors and personal representatives, release, hold harmless and discharge forever my attorney, and his/her heirs, assigns, executors and personal representatives for any and all liability, claims, losses, damages, costs or expenses and waive any such claims arising directly or indirectly from health care decisions made by my attorney pursuant to this power of attorney.

I, on behalf of myself and my minor child, agree to be financially responsible for any and all health care treatment arising in connection with any illness or injury of my minor child and the costs thereof and I agree to compensate my attorney for any such costs.

The rights, powers and authority of my attorney shall commence on Nov. 16, 2017 and shall remain in full force and effect through Nov.19, 2017 unless this power of attorney is revoked prior to that time.

IN TESTIMONY WHEREOF, witness my signature:

Printed name: ______________________________
Signature: ______________________________
Date: ________________

STATE OF KENTUCKY
COUNTY OF KENTON

Subscribed, sworn to and acknowledged before me this _____ day of ______________, 20__.

My Commission Expires: ____________________ Notary Public ____________________