ASHFORD UNITED METHODIST CHURCH
2201 S DAIRY ASHFORD RD, HOUSTON, TEXAS 77077
281-497-1146

CONSENT TO TREAT FORM

(Please complete one form for each child participating, sign, and return)

Child's Name _____ Birthdate _____ Gender (M/F) ____

Address _____

City _____ ZIP _____ Phone _____

Medical Allergies _____

Medical Conditions that restrict activities _____

_____

Mother's Name _____

Home Phone _____ Cell Phone _____

Father's Name _____

Home Phone _____ Cell Phone _____

Family's Health Insurance Co. _____

Policy# _____ Phone Number _____

Doctor's Name_____ Phone Number _____

Doctor's Address _____

In case of illness or emergency, if parents' or child's physician cannot be reached, please contact:

1. Name _____Home _____Cell _____

2. Name _____Home _____Cell _____

☐ In case of emergency, please take my child to the nearest available doctor, hospital or medical clinic.

☐ I prefer my child be taken to _____ hospital instead of the closest available emergency medical facility.

Date of last tetanus shot _____

Current Medications and Condition taking for _____

_____

_____
Parent or Guardian's Name (Please Print)

_____ _____
Parent or Guardian's Signature (Date)

Revision: 2017