ALDERSGATE UNITED METHODIST CHURCH

Visitor Authorization
Consent Form
Special Information for Open Arms

Date _____

DEPENDENT'S NAME_____
last first middle

_____IS THE NAME OR NICKNAME PREFERRED.

STATE DIAGNOSIS OR DESCRIBE YOUR DEPENDENT'S SPECIAL NEEDS:
_____

_____

_____

PARENT"S/GUARDIAN'S NAME_____

Address: _____

City _____ State _____ Zip _____

Email: _____

Home Phone: _____

***Mobile Phone or Pager in use while child is at OPEN ARMS**_____

IN THE EVENT OF AN EMERGENCY, THE FOLLOWING PERSON MAY BE CALLED AND IS AUTHORIZED TO PICK UP MY CHILD.
Positive identification must be provided before your child will be released.

Name_____ Relationship_____

Phone_____

- I authorize Open Arms to administer medical assistance in case of an emergency. I understand that in case of a medical emergency, 911 will be called. Upon arrival, EMS will administer emergency assistance and if necessary, my dependent will be transported to the nearest medical facility for treatment. I understand that I will be contacted immediately by Open Arms' staff via the phone numbers I provided at the check-in desk. I understand that I will be responsible for payment of all EMS, hospital, and physician charges for emergency services for my dependent.

- I have fully disclosed to Aldersgate United Methodist Church all pertinent facts about my dependent's special needs and accept full responsibility for failure to do so.

By signing below, I understand and agree with the above listed items and authorize Open Arms at Aldersgate United Methodist Church to care for my dependent on this second Saturday of the month from 2:00-5:00PM.

Parent/Guardian Signature: _____ Date: _____

Staff Review: _____ Date: _____