

Sunrise United Methodist Church
Medical, Permission, Liability and Photograph Release Form
8/21/2011 – 8/31/2012

We (I) the parent(s) or legal Guardian(s) of _____ hereby grant our (my) permission for him/her to participate fully in the events and activities sponsored by or attended by Sunrise United Methodist Church during the time period of August 21, 2011 through August 31, 2012. Authorization and permission is hereby given to said church (Sunrise UMC) to furnish any necessary transportation, food, and lodging, for this participant during the excursions and activities of the youth ministry program.

I understand all safety precautions will be taken at all times by Sunrise United Methodist Church and its agents during all events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Sunrise United Methodist Church, its leaders, employees, and/or volunteer staff liable for damages, losses, diseases, or injuries incurred by the participant who is the subject of this form. Furthermore, I, on behalf of my youth, hereby assume all risk of personal injury, sickness, death, damage, and expense as a result of participation in recreation and work activities involved therein.

I understand that in the event medical or dental intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached or the alternate contact persona cannot be reached in an emergency, I hereby give my permission to a licensed Physician or Dentist at an office or hospital selected by the activity leader to hospitalize, to secure medical treatment and/or to order an examination, injection, x-ray, anesthesia, or surgery for my child as deemed necessary.

I understand that Sunrise United Methodist Church does not carry accident or medical insurance on participating volunteers. I agree that my insurance company will be used for such medical care expenses. I am aware that I may be billed by the medical provider for any medical treatment expenses not covered by my insurance coverage and that I am responsible for the payment of any medical bills.

I do hereby certify that my child, _____, has permission to participate in all activities from August 21, 2011 through August 31, 2012. ___ Yes ___ No

I do hereby give Sunrise United Methodist Church permission to use my child's photograph in church newsletters, for television, or for area newspapers. ___ Yes ___ No

I do hereby give Sunrise United Methodist Church permission to use my child's photograph on the church website (understanding that his/her name will not be used). ___ Yes ___ No

Participant Signature Date ___/___/___

Parent/s or Legal Guardian/s Signature Date ___/___/___

Official Notary

This is the _____ day of _____, 201__.

Signature/Relationship (Parents or Guardians of minor participants)

Personally appeared before me, _____, a Notary Public of _____ County in the State of _____, the persons whose signatures appear above and acknowledged that he/she executed the within instrument for the purposes therein contained.

Witness my hand and official seal this _____ day of _____, 201__.

Notary Public

My Commission Expires: _____

**Sunrise United Methodist Church
Medical Information Form
9/1/2011 – 8/31/2012**

Youth's Name _____
Last First Mid. Initial

Date of birth ___/___/___

Preferred Name _____

Grade for 2011-2012 _____

Parent/Guardian _____
Last First Mid. Initial

Relationship to Youth _____

Address _____

Home Phone (____) _____

Work Phone (____) _____

Cell (____) _____

Parent/Guardian _____
Last First Mid. Initial

Relationship to Youth _____

Address _____

(If different from above)

Home Phone (____) _____

Work Phone (____) _____

Cell (____) _____

Contact in case of emergency (when parents/guardians cannot be reached)

Name _____ Relationship to Youth _____

Address _____

Home Phone (____) _____

Work Phone (____) _____

Cell (____) _____

Insurance Information

If you have medical insurance, your carrier will be billed for medical charges in case of illness or injury incurred during any youth ministry event or activity.

Do you have health insurance? ___ Yes ___ No

Name of Insurance Company _____

Claim address _____

Policy Number _____

Group Number _____

In whose name is the insurance? _____

**Sunrise United Methodist Church
Health Provider Information**

Personal Physician _____ Phone Number _____

Dentist _____ Phone Number _____

*If your child should require medical attention for injuries received or illnesses contracted prior to any event or activity,
please send us the necessary information to give him/her proper medical care during his/her time with the youth
ministry.*

Health History

Pre-existing or present medical conditions including allergies:

Name and dosage of any medications that must be taken. _____

Allergies to medications? _____

Concerns:

- | | |
|---|--|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Frequent Stomach Upsets |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Physical Handicap |
| <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Epilepsy/Nervous Disorders |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Any major illness during the past year? |

If any of the above are checked, please provide details (i.e. include normal treatment of allergic reactions)

Date of last Tetanus Shot _____ Date of Last Physical _____ Glasses/Contact Lenses ___ Yes ___ No

Any activity restrictions? If so, please explain.

For routine Medical Care (Headaches, scraped, or insect bites, etc...) please check the following that can be given by an adult accompanying the event or activity:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Neosporin ointment |
| <input type="checkbox"/> Motrin | <input type="checkbox"/> Dramamine |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Hydrocortisone cream |
| <input type="checkbox"/> Benedryl | <input type="checkbox"/> Other _____ |