

Emergency Medical Release Form
Youth & Children's Ministries

First United Methodist Church
420 South Hartz Rd
972-462-0471

This form is effective from September 1, 2009 through August 31, 2010.

I, _____ do hereby give my permission for my child to participate in the Youth & Children's Ministry activities with First United Methodist Church. I also consent to any hospital, medical, or surgical care and treatment as well as the administration of anesthesia, determined necessary by a qualified physician to be necessary for the welfare of my youth while said youth is under the care, custody, and control of the Youth or Children's Ministries of First United Methodist Church, and I am not reasonably available by telephone to give consent.

Youth/Child's Name _____

Address _____

Name(s) of Parent(s)/Legal Guardians(s) _____

Home phone _____ Business phone _____

Cell phone _____ Other phone _____

Alternate person to contact in case of emergency if parent cannot be reached –

Name _____ Relationship _____

Phone _____ Other phone _____

In the event my child has need of medical attention, I do hereby give my permissions for the staff or volunteers of First United Methodist Church Youth/Children's Ministry to obtain such medical treatment as deemed necessary. I understand that every effort will be made to contact me or my alternate contact person.

Expectations/Covenant

1. Respect is a key expectation at all First UMC Youth and Children's Ministry events and activities.
2. Youth and children will treat EVERYONE they come in contact with in a loving and respectful attitude and manner.
3. Possession or consumption of alcohol, illegal drugs, weapons or tobacco products are not allowed.
4. Any youth or child who does not follow the above expectations or the expectations and rules set forth during the event will be sent home at their own expense.

Youth Signature and Date

Parent Signature and Date

Insurance Information
(please attach a copy of the front and back sides of your insurance card)

Medical History/known allergies to food, drugs, bee stings, etc.

List all medications currently taken and what condition it is taken for.

Date of last Tetanus ____/____/____

Family Physician _____ Phone Number _____

Insurance Company _____ Phone Number _____

Policy Number _____ Group Number _____

**Should the need arise for simple, over-the-counter medication,
my child MAY BE GIVEN the following:**

- Aspirin
- Tylenol
- Ibuprofen
- Tums
- Pepto Bismal
- Cough medication, specifically _____
- Allergy medication, specifically _____
- Eye drops, specifically _____
- Other over-the-counter med, specifically _____

**Is there any other medical or other information which the staff or
volunteers should be aware of?**
