

ST. PAUL'S UNITED METHODIST CHURCH RELEASE FROM LIABILITY
AND AUTHORIZATION FOR TREATMENT OF A MINOR

I, _____, being the parent or legal guardian of _____ consent for my child/youth to participate in all children and youth activities sponsored by the St. Paul's United Methodist Church and release the Church from any and all claims, costs, liabilities, expenses, decrees, or judgments, including attorney's fees and court costs arising out of my child's participation in any such activities, or any accident, illness, or injury resulting, therefrom, or in travel to or from such participation and hereby agree to indemnify and hold harmless the Church from and against any and all such claims.

As used in this authorization and release, the term "Church" shall be understood to include, not by way of limitation, all paid and unpaid staff, committees, boards, and membership.

I further give my consent to any adult leader of any children/youth activity sponsored by the Church to secure emergency medical and surgical treatment for my child, which may be considered to be necessary in the situation in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved. I also give any adult leader permission to administer over the counter medications to my child/youth at a children/youth activity. I acknowledge that my child/youth may not drive themselves to or from any children/youth activity outside of the church, and that all driving adults will be 21 years of age or older.

This release and authority shall be valid for any children/youth activity in which my child participates, unless revoked in writing prior to the date of that activity.

Parent/Legal Guardian Signature

Parent/Legal Guardian Signature

Parent/Legal Guardian Print Name

Parent/Legal Guardian Print Name

Home Address

Home phone

Parent's Work Phone

Parent's Work Phone

Emergency Contact

Phone

Additional contact numbers, i.e. cell phone, pagers, etc

Please complete both sides
MINOR'S MEDICAL INFORMATION
(PLEASE PRINT)

Minor's Full Name

Birth Date

Address

City

State

Zip Code

Allergies

ALL Medications

Any Health Problems

Family Doctor

Phone

Medical Insurance Carrier

Policy #

Insured Member's name

Date of last Tetanus shot

Hospital Where Treated Previously

Hospital Preference

Phone

Ambulance

Phone