



2010-2011

**MEDICAL RELEASE / LIABILITY WAIVER/PICTURE RELEASE
WESLEY MEMORIAL UNITED METHODIST CHURCH**

Youth Name: _____

Parent/Guardian: _____

Address: _____

Home Phone: _____

Emergency contact

Mom's cell: _____

Name: _____

Dad's cell: _____

Phone: _____

Insurance Information

Policy-holder name: _____

Policy-holder's date of birth: _____ Youth's date of birth: _____

Medical insurance company: _____

Policy #: _____

Insurance agent: _____ Phone: _____

Address: _____

In consideration of my child being allowed to participate in Wesley Memorial United Methodist Church Student Ministry activities (youth events, mission trips, etc.), I hereby assume all risks and release Wesley Memorial United Methodist Church, its employees, and volunteers from all liability whatsoever for any injuries or accidents in connection with my child's participation. I intend this release to be binding not only for myself, but also on my family and all legal successors in interest. I also understand that in consideration of my child being allowed to participate I give the right to Wesley Memorial United Methodist Church and Student Ministries to post pictures of my child on the Wesley Memorial Student Ministry website or the church website.

In the event that my child is injured, I hereby give permission to the physician or medical personnel selected by Wesley Memorial United Methodist Church staff or volunteer to hospitalize, secure proper treatment or medication for, and to take whatever medical actions are necessary to treat my child, and I authorize the physician or medical personnel to provide treatment deemed necessary by them.

(Parent or Guardian Signature)

(Date)

(Notary Signature)

(Expiration Date)

MEDICAL INFORMATION LISTED ON REVERSE SIDE OF THIS FORM

Youth Name:	
Date of Birth:	
Youth Social Security Number:	
Home Address:	
Parent's Name (s):	
Father's Employer & Phone Number:	
Mother's Employer & Phone Number:	
Insurance Company:	
Policy Number:	
Date of Last Tetanus shot:	
List of allergies:	
Emergency contacts & phone number: other than parent or guardian:	
Physician's Name & Phone Number:	
General Medical History:	
Prescribed or over the counter medication:	
Limitations of Activities:	
I Give Permission to Administer Over the Counter Medications Except Listed Below:	Parent's Signature:
Over-the-counter Restricted List:	