Fairport United Methodist Church

Youth & Children's Ministry
Medical Release Form

______________________________ of ____
Parent/Guardian Name *Address, City, State, Zip*

is the ________________________ of________________________________
Relation *Youth/Child's Name*

of ____.
Address, City, State, Zip

I hereby give my consent, in the event all reasonable attempts to contact me have been unsuccessful, for immediate medical treatment as required in the judgment of the attending physician while

________________________ is absent from home from August 2015 to August 2016.
Youth/Child's Name *Date* *Date*

Youth/Child's Date of Birth _______________

Parent(s)/Guardian(s) Phone Numbers

Name __________________ ________________

Work ______________________________ ______________________________

Home ______________________________ ______________________________

Cell ________________________________ ______________________________

Physician: ___________________________ Dentist _____________________________

Phone Number ______________________ Phone Number ______________________

Medical Insurance Company ____

Policy Number ______________________________

Name of Insured ____

Additional information needed on back

Date of Approval 06.06.2006
Last Revision 06.19.2006

The Following information is needed by those chaperoning your youth/child and will be needed by medical personnel in the event that emergency care is sought. Please be specific and complete.

Allergies ____

Medications being taken ____

Does youth/child carry medication with him/her? _________

Can youth/child self medicate?_________

Date of last tetanus shot: _______________

Physical impairments: ____

Other pertinent facts to which physician should be alerted:

____

If parent/guardian cannot be reached in case of emergency, call:

____ Phone ____________________

____ Phone ____________________

In a medical emergency, I consent to the chaperone or appointed agent, his/her or their discretion in using, taking, arranging for or consenting to the procedures or treatment necessary. I agree to indemnify and hold harmless the Fairport United Methodist Church, the individual members, agents, employees and representatives thereof, for any and all claims, demands, actions, rights of action, and/or judgments by or on behalf of the above named member arising from or on account of said procedures and/or treatment rendered in good faith and according to accepted medical standards.

I assume the total financial responsibility for the above named member and will not hold the Fairport United Methodist Church responsible in the event of a medical emergency.

____

Signature of parent or guardian *Date*

____

Signature of Witness *Date*

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