

**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, 2011 through August 31, 2012.**

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.**

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

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**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:**

- 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?**

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