

CENTER UNITED METHODIST CHURCH

AUTHORIZATION TO PARTICIPATE

PARTICIPANT’S INFORMATION

Name _____ DOB _____ Male/Female

Nickname _____ School: _____ Grade _____

Primary Address: _____

Secondary Address: _____

Email _____

HomePh: _____, CellPh: _____

PARENT/GARDIAN INFORMATION: (To be completed if participant noted above is under the age of 18 years)

Name(s) _____

Email(s) _____

List all phone numbers where the parent/guardian can be reached (type: i.e. h: home, c: cell)

Name: _____ # _____ Type? ____

Name: _____ # _____ Type? ____

Name: _____ # _____ Type? ____

Name: _____ # _____ Type? ____

EMERGENCY-CONTACT-

Name: _____ Relation? _____

_____ # _____

Name: _____ Relation? _____

_____ # _____

PARENTAL CONSENT

The undersigned does hereby give permission for my child named below: _____, to participate in any Center United Methodist Church children/youth ministries, activities, events, retreats during the period of September 1, 20__ to August 31, 20__.

2014 F-1500.1 Authorization to Participate updated Jul 31, 2014

LIABILITY RELEASE: I, the undersigned, do hereby release, forever discharge and agree to hold harmless Center United Methodist Church, its pastors, directors, employees, volunteers and teachers (collectively herein the “Church”) from any and all liability, claims or demands for accidental personal injury, sickness or death, which may be incurred by the undersigned and the Participant while involved in the children/youth activities. I the parent or legal guardian of this Participant hereby grant my permission for s/he to participate fully in children/youth ministry activities, including trips away from the church premises. Furthermore, I, on behalf of my minor Participant, hereby assume all risk of accidental personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein. The undersigned further hereby agrees to hold harmless and indemnify said Church for any liability sustained by said Church as the result of the negligent, willful or intentional acts of said Participant, including expenses incurred attendant thereto.

MEDICAL TREATMENT PERMISSION: I authorize an adult, in whose care the minor has been entrusted, to consent to any emergency x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital or emergency care facility. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child or youth pursuant to this authorization.

EARLY RETURN HOME POLICY: Should it be necessary for my child or youth to return home due to medical reasons, disciplinary action or otherwise, the undersigned shall assume all transportation costs and responsibility.

TRANSPORTATION PERMISSION: The undersigned does also hereby give permission for my child/youth to ride in any vehicle driven by a Safe Sanctuaries approved and licensed adult volunteer/chaperone while attending and participating in activities sponsored by Center United Methodist Church. My child/youth and I understand that seat belts, when available, must be worn at all times during transportation.

 Name of youth participant x Signature of youth participant _____ Date

 Name of parent/guardian x Signature of parent/guardian _____ Date

MEDICAL INFORMATION

PARTICIPANT INFORMATION (Please Print)

Full Name _____

DOB _____ Nickname _____

Home Address _____

Home Phone _____

PARENT/GUARDIAN EMERGENCY CONTACTS

Parent/Guardian Name(s): _____

List all parent/guardian contact phone numbers in best order to be reached:

1) _____, 2) _____,

3) _____, 4) _____

NON-PARENT/GUARDIAN EMERGENCY CONTACTS

Name: _____

Relationship to Participant: _____

Phone(s): 1) _____ 2) _____

PRIMARY CARE PHYSICIAN

Name: _____

Phone _____ Fax: _____

Name of practice: _____

Date of last Tetanus shot (required) _____

INSURANCE INFORMATION

Medical Insurance Company: _____

Med Ins Co Phone: _____

Policy/Group ID# _____

Policy Holder's Name (please print) _____

Required: Attach a copy of medical insurance card here.

MEDICATION: List all medications that will take during any trip, retreat, or event. This includes any prescription, non-prescription -medications, herbal supplements and vitamins. Please Note: Any participant under the age of 18 is required to give **ALL MEDICATIONS to the adult youth leader in their original containers with complete dispensing instructions before the start of the event.**

| <u>Medication Name</u> | <u>Dose</u> | <u>Treatment for</u> | <u>Dispensing instructions</u> |
|------------------------|-------------|---------------------------|---------------------------------------|
| <i>Example: Zyrtec</i> | <i>5mg</i> | <i>Seasonal allergies</i> | <i>one pill daily in AM with food</i> |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Over-the-Counter Medication Permission: Do you give permission for your child/youth to be given over-the-counter medication as needed and as directed on the label, to treat non-emergency medical conditions that do not require a doctor or hospital visit such as a minor headache, stomachache, or allergic reaction (i.e. Advil, antacids, Benadryl) while on trip, retreat, or event?

NO. Contact me or get medical help if my child has any minor medical concerns. Parent signature _____

YES. I give permission for an adult youth leader to give my child Over the counter medications as directed on an as needed basis to treat non-emergency medical conditions. Parent Signature _____

MEDICAL CONDITIONS: Please answer in detail if applicable or write N/A. Attach additional pages if necessary.

1. List any medical conditions the participant has (asthma, diabetes, epilepsy, etc.):
2. List any allergies (drug/medicine, food, and/or environmental) and the severity and type of reaction:
3. Please explain any other pertinent information about the participant (i.e. physical, behavioral, or emotional) that would be important for the leaders of the group to know.