

MEDICAL RELEASE & INSURANCE INFORMATION
Valid September 1, 2008 to September 1, 2009

Name of Child _____
Insurance issued in the name of _____
Is Coverage for Dependents? _____
Medical/Health Insurance Co. Name: _____
Policy Number: _____ Group Number _____
Preauthorization Phone #: _____

I certify that the above-named is my child or my legal ward and resides with me. In the event he/she becomes ill, is injured, or for any reason requires medical treatment while attending a First United Methodist church function or activity, I do hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physician selected by agents or officials of the First United Methodist Church. In the event treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/we hereby authorize the Staff at First United Methodist Church or any other representatives of First United Methodist Church, to give such consent and further agree to hold any person harmless from any claims, demands, suits of any nature arising from the giving or such consent so long as the treatment is administered by or under the supervision of a licensed physician. I further authorize the release of the listed medical information to appropriate medical personnel and/or the health coverage insurance company. I will notify the church if I feel there are any health considerations that would prevent my child's participation in any activity. I also give my permission for leaders to restrict my child from participation in any activities that they have any questions about for health or other reasons.

The intention of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. I will see that payment is made for all medical expenses incurred for medical treatment for the above named youth. This payment will be made by myself or by my insurance company providing coverage for the above-named youth.

As the parent (or legal guardian), I the undersigned, certify that my child, named above, has my express permission to participate in all activities, of any nature, sponsored by First United Methodist Church for the 2007-2008 calendar year. I fully release First United Methodist Church, its authorized representatives and staff from all liability of any kind and character upon any claim, demand, or cause of action that might be asserted in our behalf against said church, representatives or staff.

Signature of Child: I _____ understand and agree to abide with the restrictions placed on my activities by my parent/guardian.

Signature of Parent/Guardian: _____ **Date:** _____

Sworn to and subscribed before this _____ day of _____.

NOTARY PUBLIC

State of Alabama, My Commission expires:

PRINT, TYPE OR STAMP COMMISSIONED NAME
OF NOTARY PUBLIC

Personally known _____ or _____ Produced identification (list type)

**'08 – 09 FUMC Children's Ministry
CHILD'S MEDICAL INFORMATION**

Child's Full Name _____ Date of Birth _____
 Soci8al Security No. _____ Male() Female () Age _____
 Address _____ Home Phone _____
 City / Zip _____ Email _____

Person to contact in case of emergency:

Name & Relation _____ Home Phone _____
 Occupation _____ Work Phone _____
 Cell Phone _____

Physicians Name _____ Phone _____

HEALTH HISTORY (check all those that apply)

DISEASES

ALLERGIES

Frequent ear infections__	Chicken pox__	Penicillin_____
Frequent Colds /Sore throat__	Measles_____	Aspirin_____
Sinusitis / Bronchitis__	Mumps_____	Other_____
Strep Throat _____	German Measles_____	Food_____
Mononucleosis_____	Whooping Cough__	Insect Stings_____
Heart Defect / Disease_____	Tuberculosis_____	Poison Ivey /Oak/Sumac_____
Epilepsy / Convulsions_____	Polio_____	Hay Fever, etc._____
Bleeding / Clotting Disorders _____	Diabetes_____	SUBJECT TO: Sleep Walking
Hypertension_____	Asthma_____	Fainting__Bedwetting_____
Stomach Problems_____	Arthritis_____	Constipation__Other_____

Other Diseases or Details of Above _____

Are immunizations up to date? _____ If no, please explain _____

Date of last Tetanus shot _____ Date of last TB skin test _____

Any activity limitations? _____ Do you wear contacts? _____

Any specific activities to be encouraged? _____

List any medications or drugs taken regularly _____

Any special medical or dietary regime to be continued? _____