Consent & Medical Release Form 2018

First United Methodist Church – Punta Gorda, FL

Student Name:_____ Date of Birth: _____/_____/_____

Address:_____ City: _____

State: _____ Zip: _____ Student Cell Phone: (_____)_____ Check if N/A ☐

Student email address: _____

Parent/Guardian email address: _____

Father's Name: _____ Cell Phone: (_____)_____

Mother's Name: _____ Cell Phone: (_____)_____

If the address or for either parent is different than that of the child, please provide this information:

Address:_____

Father's Work Phone: (_____)_____ Mother's Work Phone: (_____)_____

Emergency contact/authorized alternate pickup person(s) if parent/guardian is unavailable:

Name:_____ Phone: (_____)_____ Relationship: _____

Name:_____ Phone: (_____)_____ Relationship: _____

I have read and understood all sections of this form that apply to my child. I certify that the above-named youth is my child or my legal ward and resides with me and has my consent to participate in **1st United Methodist Church** sponsored activities. I understand that pictures, video and other forms of media which may contain images or the voice of the above-named youth may be use be used in promotional or informational materials produced by **1st United Methodist Church**. By providing the email address and/or student cell phone number, I/we hereby authorize the Youth Minister and other volunteers acting on behalf of the **1st United Methodist Church,** to contact my child using these electronic methods. I also agree that in the event that above-named youth becomes ill, is injured or for any reason requires medical treatment while attending a **1st United Methodist Church** event or activity, the undersigned(s) and/or legal guardian(s) of the above-named youth hereby consent to any and all medical or surgical treatment, including anesthesia and operations, which may be deemed advisable by any qualified physicians selected by agents or officials of the **1st United Methodist Church**. In the event that treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/we hereby authorize the Youth Minister, Timothy Buck or other responsible adult accompanying this **1st United Methodist Church** group, to give such consent and further agree to hold any person harmless from claims, demands or suits of any nature arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician. 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 patients care, be deemed advisable or necessary by any qualified physician. Payment for all charges incurred for medical treatment is guaranteed by the parent/guardian, or insurance company providing coverage for the above named youth.

Medical/Health Insurance Co. Name_____

Policy No:_____ Group No:_____

In connection with the provision of such medical treatment, be advised of the following regarding the above-named person:

Handicap, limitation or medical condition(s): _____

Allergies (general or to medication): _____

Presently taking the following medication (name, dosage & reason it is taken): _____

_____

_____

Signature of Parent / Guardian

Sworn to and subscribed before me this _____ day of _____, 20_____

_____ *Notary Public, State of Florida, My commission expires:* _____

*Print, Type or Stamp Commissioned name of Notary Public:*_____

*Personally known:*_____ *or Produced Identification:* _____ *Type of ID produced*_____