

## **United Methodist Church of Whitefish Bay Youth Ministries Medical Release Form**

This will be kept in a confidential file in the Youth Ministry Office. Please direct all questions to the Director of Youth Ministries, Melissa Swanson, by phone: (414) 964-2424, x137, or by email: mswanson@umcwfb.org.

This Consent Form gives permission to seek whatever medical attention is deemed necessary and releases the United Methodist Church of Whitefish Bay and its staff of any liability against personal losses of named child.

I/we, the undersigned, have legal custody of the youth named, a minor, and have given our consent for her/him to attend events being organized by the United Methodist Church of Whitefish Bay. I/We understand that there are inherent risks involved in any ministry or event and I/we hereby release the Church, its pastors, employees, agents and volunteer workers from any and all liability for any injury, loss or damage to person or property that may occur during the course. I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands or suits for damages arising from the giving of such consent. I/we acknowledge that I/we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider.

Furthermore, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the youth named.

I/we also agree to bring my/our child home at my/our expense should they become ill or if deemed necessary by the Youth Ministries Staff.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Parent/Guardian name** \_\_\_\_\_

*Please return this to the Church office or the Office of the Director of Youth Ministries. Thank you.*

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## PERSONAL INFORMATION

Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Birthday \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Mother's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Student \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION-Complete all that applies** Year of last tetanus \_\_\_\_\_ **VERY IMPORTANT**

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group # \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Please describe any physical and/or psychological conditions your child has that the staff should be aware of, and what, if any, action of protection is required. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken. Please be aware that all medications must be kept with an adult and cannot be left in the possession of the youth with the exception of inhalers.

## Check the following areas of concern for your youth. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your youth a \_\_\_good swimmer \_\_\_ fair swimmer \_\_\_ non-swimmer
2. List all known allergies \_\_\_\_\_
3. Does your child suffer from or has ever experienced or is being treated currently for any of the following:  
\_\_\_asthma\_\_\_diabetes\_\_\_epilepsy/seizure disorder\_\_\_frequent stomach problems\_\_\_physical handicap\_\_\_other
4. Does your child wear \_\_\_prosthetics \_\_\_glasses \_\_\_contact lenses \_\_\_hearing aid

**PLEASE REMEMBER TO READ AND SIGN THE BACK!!!**