

Greensburg United Methodist Youth
Parental Consent Form/Liability Release
Effective from September 1, 2015-August 31, 2016

Youth's Name _____ Age _____ Birthday _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Current Grade _____

Parent's Cell Phone # (____) _____ Work Phone # (____) _____

Emergency Contact # (____) _____ Name _____

Alternate Contact # (____) _____ Name _____

PARENTAL CONSENT:

As parent/guardian of _____ I hereby give my permission for my child or ward to attend and participate in the activities sponsored by Greensburg United Methodist Youth (GUMY) and Greensburg United Methodist Church (GUMC). I do hereby hold harmless GUMC and GUMY, its Directors, Officers, Employees, Volunteers, or Agents of said organization, for any bodily injury, illness or disease, or for loss or damage to any property or appliance of said child or ward. I assume the risk and financial responsibility for any injury or liability resulting from his/her participation. In case of a medical emergency, I understand every reasonable effort will be made to contact me. In the event I cannot be reached, I hereby give permission to secure proper treatment for, and order injection or anesthesia or surgery for my child or ward as named above. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to him/her. The undersigned does also hereby give permission for said child or ward to ride in any vehicle designated by the staff of GUMC and/or GUMY while attending or participating in activities sponsored by GUMC and/or GUMY. I consent to the use of any video images, photographs, audio recordings, or any other visual or audio reproduction that may be taken of said child or ward while participating in activities sponsored by GUMC and/or GUMY, to be used, distributed, or shown as GUMC and/or GUMY sees fit.

Student Signature (if over 18) _____

Print Name _____ Date _____

Parent/Guardian Signature (if child is under 18) _____

Print Name _____ Date _____

Please complete and sign the reverse side of this form.

Medical Form

Youth's Name _____ Birthday _____

Check Boxes That Apply:

Allergies

- Food _____
- Peanuts _____
- Other _____
- Seasonal _____
- Aspirin _____
- Penicillin _____
- Other Drugs _____

Illnesses

- Heart Condition _____
- Convulsions/Seizures _____
- High Blood Pressure _____
- Fainting _____
- Frequent Upset Stomach _____
- Asthma _____
- Migraine Headaches _____
- Other _____

Are there any routine treatments or medications needed by your child on a daily basis?

- No
- Yes If yes, please list _____
- The child can take their medication on their own.
- The child must have this administered by an adult.

Insurance Information

Does the child have medical insurance?

- No
- Yes
Insurance Company _____
Insurance Policy # _____

Parent or Guardian Signature _____ Date _____