

Medical Release Form  
First United Methodist Church  
Children's Ministry  
2011

Child's Name \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

Email: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

Your signature on this form authorizes the use and listing of your child's name and/or photo for marketing and/or newsworthy events pertaining to FUMC and/or Children's Ministry.

I understand that **First United Methodist Church** (ministry) carries medical and hospitalization insurance coverage which, consistent with the exclusions, limitations and terms thereof, may provide benefits over and above any personal medical and hospitalization coverage available to my family. I understand that any personal medical and hospitalization insurance available to my family will provide primary coverage and the ministry medical and hospitalization coverage (subject to the exclusions, limitations and provisions in the ministry's policy) may provide secondary or excess coverage. I agree to apply first for benefits from the personal hospitalization and medical coverage available to my family, if any, before applying for benefits that may be available from the ministry's medical and hospitalization coverage.

I further understand that, in the event my child requires medical or dental treatment while engaged in the activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's representative or any adult counselor acting on behalf of the ministry with respect to the activity, as agent for me, to consent to any x-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_