

**PULASKI HEIGHTS UMC CHILDREN & YOUTH MINISTRIES
PERMISSION FOR MEDICAL TREATMENT/TRANSPORTATION**

Activity: All Youth Ministry Activities Sponsored by PHUMC for the 2019-2020 School Year

Student 1:

First Name of Participant: _____ Middle Name: _____ Last Name: _____

Name You Go By: _____ Date of Birth: _____

Grade Level: _____ School: _____ Check One: Male Female

Cell Phone: _____ Email: _____

Student 2:

First Name of Participant: _____ Middle Name: _____ Last Name: _____

Name You Go By: _____ Date of Birth: _____

Grade Level: _____ School: _____ Check One: Male Female

Cell Phone: _____ Email: _____

Student 3:

First Name of Participant: _____ Middle Name: _____ Last Name: _____

Name You Go By: _____ Date of Birth: _____

Grade Level: _____ School: _____ Check One: Male Female

Cell Phone: _____ Email: _____

Address & Home Phone For All Students:

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

Parents/Guardian:

Mother's Name: _____ Home Phone: _____ Cell Phone: _____

Mother's Work Phone: _____ Mother's Email: _____

Father's Name: _____ Home Phone: _____ Cell Phone: _____

Father's Work Phone: _____ Father's Email: _____

Insurance

Medical Insurance Company (If none, please note.): _____

Insurance ID #: _____ Group or Policy #: _____

Allergies: _____ Wear contact lenses? _____

Current medications (Prescription and over the counter) : _____

Emergency Contact (If parent is not available)

Name of emergency contact person other than parent: _____

Street and/or mailing address: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

AUTHORIZATION

I hereby waive, release and covenant not to sue Pulaski Heights United Methodist Church and its officers, agents, employees, volunteers or activity chaperones from any and all negligence or fault which might proximately cause any claim, injury, death or liability resulting from my child's participation in church sponsored activities.

I further give my permission for my child to be transported by church employees, volunteers or chaperones as part of his/her participation in this activity. I further hereby authorize and direct that the sponsors for this event be authorized to consent to medical treatment by qualified and licensed medical practitioners in the event of a medical or dental emergency, which, in the opinion of the attending physician, should be administered.

**Print
Clearly
Please!**

(Name of Parent or Guardian Printed)

(Date)

(Parent or Guardian Signature)

****Please provide a copy of your insurance card****