Medical Release Form-Ashland UMC Youth Ministry

Name of Youth _____ Today's Date _____

I give permission for photographs to be taken of my child that may be used in church publications or materials (print or electronic). ☐ Yes ☐ No

Health Information:
Medical conditions we need to know about your child _____
_____
Allergies _____
Medications taking _____

Insurance Information:
Insurance Company _____Phone#_____
Policy Number _____ Group Number _____
In whose name is the insurance? _____
Youth's Physician _____ Phone #_____

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I (we) cannot be reached, I give my permission for medical treatment to the physician or dentist selected by the adult leaders of Ashland United Methodist Church. I understand that my insurance coverage will be used as primary coverage in the event a medical emergency occurs.

I, the undersigned parent or guardian of _____, a minor, do hereby authorize Ashland United Methodist Church, its pastors, staff and volunteers to consent to any examination, x-ray, anesthetic medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon on the staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.
Further as parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from any physician hospital or further agree to release, hold harmless and indemnify the church, its pastors, staff, members, and volunteers for any claims for injuries to person or damage to property of what so ever kind or nature arising out of or resulting from the matters contemplated by this form. This authorization shall also include emergency first aid performed by church staff or volunteers.

Signature of Parent or Guardian_____Date_____