Leola United Methodist Church

YOUTH FELLOWSHIP

MEDICAL RECORD AND LIABILITY RELEASE FORM

Date signed:_____

SECTION 1: MEDICAL RECORD AND INSURANCE

Full Name: _____ Date of birth: _____

Address: _____

City/State/Zip: _____ Home phone: (____) _____

MEDICAL INSURANCE INFORMATION

Is this person covered by a medical insurance policy? Yes _____ No _____

Name of policy holder: _____ Relationship to participant: _____

Insurance company: _____ Phone #: (____) _____

Medical insurance policy number: _____ Check one: Group plan: ____ Individual/Family plan: ____

MEDICAL HISTORY

Blood Type: _____

List allergies or allergies to medications: _____

_____

List medication(s) presently taking: _____

_____

Please describe any medical problems or conditions inc. mental & emotional _____

_____

_____

List any restrictions on sports or physical activity: _____

_____

I hereby give permission for the person listed above to be treated with the following medications (Check medications you approve for this person to receive): ____ Tylenol ____ Aspirin ____ Pepto Bismol ____ Ibuprofen ____ Antacid products

List any medications person should not have: _____

_____

Doctor's name: _____ Doctor's phone: (____) _____

SECTION II: MEDICAL TREATMENT RELEASE AND LIABILITY RELEASE

I, the undersigned parent or guardian (or self if adult 21 or over), do hereby grant permission for _____ to attend the Youth Events. I hereby authorize the event staff to obtain and consent to medical treatment for my child in case of injury or illness during the Youth Event. And I hereby release and discharge the Youth Pastor and staff of Leola United Methodist Church, and the United Methodist Church and its representatives, employees, volunteer staff, and agents from any and all debts, judgments, or suits of any kind which may arise or be occasioned as a result of the participant's participation in the Youth events.

I further acknowledge and understand that by participating in the Youth Events there is a possibility of physical illness or injury and my child (or self if 21 or over) is assuming the risk for such illness or injury by his/her/my participation. It is my understanding that payment of any medical bills will be paid by me or by my insurance company.

_____ _____

Signature of Parent, Guardian, or self if 21 or over — Name of Parent, Guardian, or self (printed)

_____ (____) _____

Person to call in case of emergency — Emergency phone number

_____ (____) _____

Alternate person to call in case of an emergency — Alternate emergency phone number

(OVER)