STRAWBRIDGE UNITED METHODIST CHURCH
EMERGENCY TREATMENT CONSENT AND INFORMATION FORM

Name:_____ Sex:____ Date of Birth:_____ Grade:____
Last First Middle
Address:_____ Zip:_____ Home Phone:_____
Person Participating Email: _____ Cell Phone: _____

Parent/Guardian:_____ Email: _____ Work Phone:_____
Home Phone: _____ Cell Phone: _____
Parent/Guardian:_____ Email: _____ Work Phone:_____
Home Phone: _____ Cell Phone: _____

In cases where parent/guardian is unavailable, name of friends/relatives to be contacted in the event of an emergency:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

In order to meet all legal requirements, I hereby grant permission for _____ (minor's name) to participate in Strawbridge United Methodist Church programs.

I understand that my signature and initials convey the following:

(___) (1) My authorization for the adult leader to obtain necessary emergency medical and/or dental treatment for said minor.
(___) (2) I knowingly release, absolve, indemnify and hold harmless Strawbridge United Methodist Church from all claims that might result from any injury or death of any minor.
(___) (3) Should medical and/or dental treatment be required, I agree to pay all medical, dental and/or hospital care costs either directly or through my personal health and accident insurance policy(ies).
(___) (4) I give permission for Strawbridge United Methodist Church to include my child's photo in any form or media which may be posted on bulletin boards and/or printed in publications and advertisements for the church.
(___) (5) I give permission for Strawbridge United Methodist Church to include my child's photo on the Church web site and other social media. (such as Internet, Twitter and Facebook)
(___) (6) I give permission for Strawbridge United Methodist Church to provide transportation to and from all events.

Signature: _____ Date: _____

(Please complete emergency medical information on back.)

This agreement will remain in effect for one year from the date above, or until revoked by me in writing.

Please provide copy of your insurance card (front and back) and attach to this form.

EMERGENCY MEDICAL INFORMATION

Medical Information for _____

Physician Name_____ Phone_____
Address_____ Zip_____

Dentist Name_____ Phone_____
Address_____ Zip_____

Medical/Hospitalization Insurance Provider
Company Name_____
Address_____ Zip_____
Policy Holder Name_____
Policy Number _____

Date of last Tetanus Shot _____

Recommended Immunizations Current? (based on minor's age) Yes____ No____

____No known allergies _____ (Please initial)

Known allergies to:

____ Penicillin _____ ____ Poisonous plants _____
____ Other drugs _____ ____ Insect bites _____
____ Food _____ ____ Other _____

Chronic or recurring medical/health problems (i.e. asthma, bronchitis, diabetes, use of EPI Pen etc.):

_____

_____

Regularly used medications:

_____

_____

Indicate any activity restrictions:

_____

_____

Other comments or suggestions from the parent or guardian concerning this minor:

_____

_____

Please return completed form to the church office.

Revised 1-2016