

# Form #10

## Church of the Master Children's Medical/General Permission Form

Effective dates: **September 1, 2019 – August 31, 2020**

**Please print in ink. Please complete one form per child.**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

LAST

FIRST

MIDDLE

Year in school: \_\_\_\_\_  Male  Female Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Parent/Guardian #1 Name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Parent/Guardian #2 Name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Office phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Office phone: \_\_\_\_\_

### Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

**Check the following areas of concern for this child.** If necessary, add another page with details:

1. For your child's safety and our knowledge, is your child a—

good swimmer     fair swimmer     non-swimmer

2. Does your child have allergies to—

pollens     medications     food     insect bites     other (list below)

Please List: \_\_\_\_\_

3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:

- asthma       epilepsy / seizure disorder       heart trouble       diabetes  
 frequently upset stomach       physical handicap

4. Date of last tetanus shot: \_\_\_\_\_

5. Does your child wear       glasses       contact lenses

6. Please list and explain any major illnesses the child experienced during the last year: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Should this child's activities be restricted for any reason? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Children's activities in our program may include, but are not limited to: cookouts, cooking, boating, swimming, basketball, roller skating, rollerblading, games in the park, soccer, broomball, ice skating, volleyball, softball, baseball, camping, "creeking", hiking, biking, concerts, Bible studies, golfing, miniature golf, hayrides. *Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the church prior to that event.*

\_\_\_\_\_ has my permission to attend all children's activities sponsored  
Name of Child

by **Church of the Master United Methodist** (hereinafter the "Church") from **Sept. 1, 2019 – Aug. 31, 2020.**

*This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.*

I/We the undersigned have legal custody of the child named above, a minor, and have given our consent for him/her to attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the child named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the student ministries staff member.

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_