# GOOD SAMARITAN UNITED METHODIST CHURCH

**MEDICAL RELEASE FORM—Youth Ministries**

**Valid January 2011—December 2012**

| Name: | Date of Birth: |
|---|---|
| Address: | City/Zip |
| Social Security Number: | Home Phone: |
| Father's Name: | Emergency Phone (s) |
| Mother's Name: | Emergency Phone (s) |
| Email:<br>Child's email: | |
| If the address or home phone for either parent is different than that of the child, please provide this information: | |
| Address: | Home or Work Phone: |
| Person to contact if parent(s) is/are unavailable: | |
| Relationship: | Emergency Phone (s): |

**I have read and understood all sections of this form that apply to my child. I certify that the above-named youth is my child or my legal ward and resides with me. In the event he/she becomes ill, is injured or for any reason requires medical treatment while attending a Good Samaritan United Methodist Church function or activity, the undersigned parent(s) and/or legal guardian(s) of the above-named youth do hereby consent to any and all medical or surgical treatment, including anesthesia and operations which may be deemed advisable by any qualified physicians selected by agents or officials of the Good Samaritan United Methodist Church. In the event treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/We hereby authorize an official chaperone (21 or older) accompanying the Good Samaritan Youth Ministry, or Good Samaritan United Methodist Church, to give such consent and further agree to hold any person harmless from any claims, demands, or suits of any nature arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician. The intention of this release is to grant authority to administer and perform any and all examinations, treatments, anesthetics, operations, and by diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. Payment for all charges incurred for medical treatment is guaranteed by the parent/ guardian or insurance company providing coverage for the above-named youth.**

| Medical/Health Insurance Co. name: | |
|---|---|
| Policy/Group No. | HMO Emergency Authorization Phone number: |
| In connections with the provision of such medical treatment, be advised of the following regarding the above-named youth: | |
| Handicap, limitation or medical condition: | |
| Allergies (general or to a medication): | |
| Taking the following medication (medication name and dosage): | |
| Glasses/Contact Lens: | Signature of Parent: |

Sworn to and subscribed before me this _____ day of ____________________, ____. My Commission expires: ______________

PRINT, TYPE OR STAMP COMMISSIONED NAME OF NOTARY

Before me personally appeared ______________________________ WHO IS PERSONALLY KNOW TO ME ☐ or PRODUCED IDENTIFICATION ☐ TYPE OF IDENTIFICATION—☐FL Driver's License or Other ________

______________________________ Notary Signature

______________________________ Notary Stamp