

FUMC STUDENT MINISTRY  
PERMISSION & MEDICAL RELEASE FORM  
First United Methodist Church  
201 N. Mount, Fairfield, Texas  
903-389-2225

STUDENT NAME: \_\_\_\_\_ STUDENT CELL: ( ) - \_\_\_\_\_

HOME PHONE: ( ) - \_\_\_\_\_ PARENT CELL 1: ( ) - \_\_\_\_\_ PARENT CELL 2: ( ) - \_\_\_\_\_

PHYSICAL HOME ADDRESS (street/city/zip): \_\_\_\_\_

MAILING ADDRESS (if different): \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH (mm/dd/yyyy): \_\_\_\_\_ SEX: **M** **F**

PARENT/GUARDIAN NAMES: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ BUSINESS PHONE#: ( ) - \_\_\_\_\_

ALTERNATE CONTACT (not parent/guardian): \_\_\_\_\_ Phone#: ( ) - \_\_\_\_\_

INSURANCE CO.: \_\_\_\_\_ POLICY #: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE #: ( ) - \_\_\_\_\_

DATE OF LAST TETANUS SHOT: \_\_\_\_\_

List any allergies, handicaps, or specific medical problems of which we should be aware:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ the undersigned parent or guardian of \_\_\_\_\_, has my permission to attend and participate in events sponsored by the United Methodist Church. I understand that this may involve travel on a bus, van, or in a private vehicle. I release the United Methodist Churches, its employees, and volunteers from any liability for injuries or illness which may occur on these events.

I authorize adult workers with the United Methodist Church 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 licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Further, as a parent or guardian of the minor named above, I do hereby expressly consent that my son/daughter may receive emergence medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital or other medical center for rendering such services.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Valid from August 1, 2011 to July 31, 2012**