



## Youth Medical Release Form

I/We, the undersigned, are the parents, the parents having legal custody, or the legal guardians of \_\_\_\_\_, a minor, and have given our consent for him/her to attend any youth event operated by St. Andrew's United Methodist church. In the event that he/she is injured while attending the event 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 called for, which a physician and/or hospital personnel refuses to administer without my/our consent, I/we hereby authorize Bob Davis, the lead adult of our group, or another adult sponsor to give such consent for us if I/we cannot be reached by telephone at one of the numbers listed below, or because of an emergency, there is not enough time or opportunity to make a telephone call.

In the event it becomes necessary for that person to give consent for us, 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 so long as the treatment is administered by or under the supervision of a licensed physician. I/We also acknowledge that I/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 carrier. Further, I/we affirm that the health insurance information provided below is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above at the time of the mission trip.

Name of Health Insurance Policy Holder

Health Insurance Policy Holder's Telephone Number

\_\_\_\_\_

\_\_\_\_\_

Health Insurance Policy Number

\_\_\_\_\_

Insurance Carrier's Name, Address, and Telephone Number

\_\_\_\_\_

Name, Address and Telephone Number of Policy Holder's Employer

\_\_\_\_\_

### Participant

Print Name

Signature

Date of Birth

Social Security Number \_\_\_\_\_ Date \_\_\_\_\_

### Parent/Guardian (if participant is under 18)

Print Name

Signature

Relationship to Youth

Print Name

Signature

Relationship to Youth

Known allergies and current medications:

\_\_\_\_\_

Date of most recent Tetanus Shot:

\_\_\_\_\_

*Please attach a copy of your insurance card to this form if possible.*

