

**First United Methodist Church of Kalamazoo**  
**Medical Information and Release Form**

**Student Info:**

Full Name of Child \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ HS Graduation Year: **20** \_\_\_\_\_  
Home Address \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone \_\_\_\_\_ Student Cell: \_\_\_\_\_ Student email: \_\_\_\_\_

**Additional Parent/Guardian Info:**

Parent 1 Name \_\_\_\_\_ Parent 1 email \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Parent 2 Name \_\_\_\_\_ Parent 2 email \_\_\_\_\_  
Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Persons to be contacted in an emergency if parent cannot be reached:**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**Permission to be photographed:**

I hereby grant permission to First United Methodist Church of Kalamazoo to photograph the said child during youth activities and to use the photographs in First United Methodist Church of Kalamazoo audio-visual and printed materials without compensation or approval rights.

**Parent/Guardian Initial** \_\_\_\_\_ **Participant Initial** \_\_\_\_\_

**Insurance Information:**

Insurance Company \_\_\_\_\_ Preadmission Authorization Phone # \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber number \_\_\_\_\_  
Group Name \_\_\_\_\_ Group Number \_\_\_\_\_

**Medical Information:**

Known allergies or medical allergies of participant \_\_\_\_\_  
Medications begin taken \_\_\_\_\_ Blood Type \_\_\_\_\_  
Physical handicaps or restrictions \_\_\_\_\_

I, the parent or guardian of \_\_\_\_\_, a minor, hereby release First United Methodist Church of Kalamazoo, its staff and youth advisors, from responsibility and liability for any injury or illness that my child may sustain during officially sponsored youth activities. In the event of an emergency, in which I am absent and cannot be contacted immediately, I hereby authorize an adult leader of these activities, as an agent for me, to consent to any X-ray examination; medical, dental, or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible. **This authorization shall remain in effect until the participant's high school graduation or until revoked in writing and delivered to the authorized agents of First United Methodist Church of Kalamazoo.**

Signature \_\_\_\_\_ Date \_\_\_\_\_