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| The following information is necessary should your child need treatment | |
| Name of Child | |
| Date of Birth | |
| County and State of Birth | |
| Personal Health Insurance Policy Name and Number | |

**PARENT/GUARDIAN RELEASE
FOR MANCHESTER UNITED METHODIST YOUTH EVENTS/TRIPS**

I/we understand that this form includes my transportation consent for my child's travel to and from any event.

I grant permission to the counselors attending the event from Manchester United Methodist Church to seek emergency treatment for my child by a licensed physician or hospital in the case of illness, accident or injury and grant them permission to release any information requested for the completion of medical/surgical or accident claims for my son/daughter.

I further agree not to hold Manchester United Methodist Church, or any adult counselors thereof, responsible for any accident or illness that might occur to my son/daughter while attending or traveling to and from the event sponsored by Manchester United Methodist Church.


| |
|-------------|
| Notary Seal |
|-------------|

Signature Parent/Guardian Date

Notary Public Date

| | |
|---|---------------|
| Personal Conduct Covenant | |
| I, _____, covenant with the Adult Youth Ministry Team, youth, and my parent(s)/guardian, that my actions will be appropriate during any event which I undertake. | |
| I promise that I will follow all the rules set before me in regards to the event or trip. I will not smoke or use tobacco (without prior parental consent), use drugs or alcohol or participate in behavior or activities which will embarrass the group. | |
| I understand if this covenant is broken, I will be sent home at my parent's expense as the counselors deem appropriate. | |
| _____ Student's Signature | _____ Date |
| _____ Parent's Signature | _____ Date |

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| CONSENT FOR USE OF PHOTOGRAPHS FOR PRINT, VIDEO, OR WEBSITE MEDIA | |
| <input type="checkbox"/> I consent to allow all pictures taken of my minor child, _____, to be used for publicity and/or outreach materials for Manchester United Methodist Church. I hereby indemnify and hold the above organization harmless against any and all claims or damages arising out of taking or use of any pictures or names of said minor child. | |
| _____ Signature of Parent/Guardian | _____ Date |
| <input type="checkbox"/> I DO NOT consent to the above use of photographs for print, video or web site media. | |

Over, please 

Manchester United Methodist Church

2007-2008 Health Form

| | |
|----------------------|---|
| NAME OF CHILD | Grade: _____ |
| | <input type="checkbox"/> Female <input type="checkbox"/> Male |

HEALTH STATEMENT ... Please fill this out in order that we might be more fully aware of your child's special needs and facilitate any medical attention that might be required while on the event/trip.

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|---|---|---|--|
| Parent or Guardian Name | | Home Phone # with area code: | |
| Full Mailing Address: | | | |
| NUMBERS TO BE USED IN CASE OF EMERGENCY: | | | |
| Work Phone #(s) w/ area code and names: | | | |
| Cell # (s) and names: | | | |
| Physician's Name | | Phone # | |
| Dentist's Name | | Phone# | |
| RESTRICTIONS ON ACTIVITIES - please specify | <input type="checkbox"/> None | <input type="checkbox"/> Sports | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Hiking | | | |
| Other (please specify): | | | |
| RESTRICTIONS ON DIET: | | | <input type="checkbox"/> Vegetarian |
| MEDICATIONS REQUIRED during event/trip. Give name, purpose, instructions for counselor or director: | | | |
| ARE THERE ANY MEDICATIONS YOUR CHILD SHOULD <u>NOT</u> BE GIVEN at event/trip: (i.e. aspirin, throat lozenge, laxative, etc.)? If yes, please specify. <input type="checkbox"/> yes <input type="checkbox"/> no | | | |
| ALLERGIES: | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa or other | <input type="checkbox"/> Tetanus shots |
| <input type="checkbox"/> Food (specify) | <input type="checkbox"/> Poison Ivy/Oak | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Bee or insect sting |
| <input type="checkbox"/> Other (specify) | | | |
| SUBJECT TO: | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Headaches |
| | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Homesickness | <input type="checkbox"/> Cramps |
| | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Other | |
| HAS HISTORY OF OR UNDER CARE FOR: | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| | <input type="checkbox"/> Athlete's foot | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> ADHD | <input type="checkbox"/> ADD | <input type="checkbox"/> Other |
| Date of tetanus shot/booster | | Does child have his/her appendix? | |
| Does child have his/her tonsils? | | Does child wear glasses? | |
| Does child wear contact lenses? | | Does child wear hearing aid? | |
| Does child wear orthodontic braces? | | Does child wear orthodontic retainer? | |
| Swimming Ability: <input type="checkbox"/> Beginner <input type="checkbox"/> Intermediate <input type="checkbox"/> Advanced | | | |
| Any other information that would help staff better understand and relate to your child and make his/her experience pleasant: | | | |