

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.

<p>This form MUST BE NOTARIZED for Carol Choir & Music Makers Choirs & Handbell Choirs. (Notarization is not necessary for SonShine Singers.)</p>
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<p>Notary Seal</p>

Signature Parent/Guardian Date

Notary Public Date

<p>CONSENT FOR USE OF PHOTOGRAPHS FOR PRINT, VIDEO, OR WEBSITE MEDIA</p> <p><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.</p> <p>_____ Signature of Parent/Guardian Date</p> <p><input type="checkbox"/> I DO NOT consent to the above use of photographs for print, video or web site media.</p>
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[over please]

Manchester United Methodist Church Health Form

date: _____

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

Parent or Guardian Name	Home Phone # with area code: _____
Full Mailing Address: _____	
Work Phone #(s) w/ area code and names: _____	
Cell # (s) and names: _____	
Physician's Name	Phone # _____
Dentist's Name	Phone# _____
RESTRICTIONS ON ACTIVITIES <input type="checkbox"/> None <input type="checkbox"/> Sports <input type="checkbox"/> Swimming <input type="checkbox"/> Hiking <input type="checkbox"/> 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"/> Swimmer's ear <input type="checkbox"/> Sleep Walking <input type="checkbox"/> Homesickness <input type="checkbox"/> Cramps <input type="checkbox"/> Bed Wetting <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"/> Stomach Ulcer <input type="checkbox"/> Athlete's foot <input type="checkbox"/> Epilepsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Tonsillitis <input type="checkbox"/> ADHD <input type="checkbox"/> ADD <input type="checkbox"/> Other _____	
Date of tetanus shot/booster _____ Does child have his/her appendix? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does child have his/her tonsils? <input type="checkbox"/> Yes <input type="checkbox"/> No Does child wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does child wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Does child wear hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does child wear orthodontic braces? <input type="checkbox"/> Yes <input type="checkbox"/> No Does child wear orthodontic retainer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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:	

[over please]