

Allergies: _____

Kirkwood United Methodist Church
201 West Adams
Kirkwood, Missouri 63122
314-966-8167

PARENTS' RELEASE & EMERGENCY TREATMENT PERMISSION

I/We _____, parent(s)/guardian(s)
of _____, give and grant him/her
permission to attend **ALL KUMY & Confirmation Activities** under the sponsorship of Kirkwood United
Methodist Church. We also release the sponsoring organization from all claims of accidental injury and
delegate to the leaders of the group or program that authority to act in case of an emergency, including all
medical and surgical treatments, should I/we not be within reach by one of the telephone numbers listed
below:

Youth's Name: _____

Birth Date: _____ Social Security #: _____

Address: _____

City/State/Zip Code: _____

E-mail Address: _____

Home Phone #: _____ Work Cell Phone #s: _____

Medical/Hospitalization Plan/Form: _____

Medical/Insurance ID #: _____

Medical/Insurance Group #: _____

PARENT/GUARDIAN SIGNATURE

DATE

Personal Conduct Covenant

I, _____, covenant with the
Adult Youth Ministry Team, youth, and my parent(s)/guardian.
I promise my actions will represent the church well during any
event which I undertake.

I promise that I will follow all the rules set before me in regard
to the event or trip. I promise to respect God, respect myself,
respect other persons, and respect property. I will not smoke or
use tobacco, drugs or alcohol or participate in behavior which
will embarrass the group.

I understand if this covenant is broken, I will be sent home at
my parents' expense as the counselors deem appropriate. I
further understand that my continued participation in church
activities depends on my support of this agreement.

Youth's Signature Date

Parent Signature Date

**CONSENT FOR USE OF PHOTOGRAPHS
FOR PRINT, VIDEO OR WEBSITE MEDIA**

I consent to allow all pictures taken of my minor
child, _____, to be
used for publicity and/or outreach materials for
Kirkwood United Methodist Church. I hereby
indemnify and hold the above organizations 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

I DO NOT consent to the above use of
photographs for print, video or website media.

Office Use Only:
Date Received

Over, please
⇒ ⇒ ⇒

Health Statement: Please fill this out in order that we might be more fully aware of your youth's special needs and facilitate any medical attention that might be required while on an event/trip.

Name of Youth:					
Parent Name(s)			Phone #:		
Address (if different from home)					
Physician's Name:			Phone #:		
Dentist's Name			Phone #:		
Allergies (Food and Medicine):					
Restrictions on Activities:	<input type="checkbox"/> None	<input type="checkbox"/> Sports	<input type="checkbox"/> Swimming	<input type="checkbox"/> Hiking	<input type="checkbox"/> Other
Restrictions on Diet:					
What over-the-counter medications may we give to your youth at an event/trip? (ex. Advil)					
Required Medications:					
Allergies:	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Tetanus Shot	<input type="checkbox"/> Other	
	<input type="checkbox"/> Poison Ivy/Oak		<input type="checkbox"/> Hay fever	<input type="checkbox"/> Bee or other insect sting	
SUBJECT TO:	<input type="checkbox"/> Fainting	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Headaches	<input type="checkbox"/> Earaches	<input type="checkbox"/> Cramps
	<input type="checkbox"/> Toothaches	<input type="checkbox"/> Swimmer's Ear	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Homesickness	<input type="checkbox"/> Exhaustion
	<input type="checkbox"/> Sleep Walk	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Stomach Upset	
	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Colds/Pneumonia			
HAS HISTORY OF OR UNDER CARE FOR:	<input type="checkbox"/> Heart Trouble		<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy
	<input type="checkbox"/> Stomach Ulcer		<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tonsillitis
	<input type="checkbox"/> Nervous Disorder		<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Hernia	<input type="checkbox"/> Athlete's Foot
	<input type="checkbox"/> Other (Please specify)				
Date of Tetanus Booster:			Does your youth have his/her appendix?		
Does your youth have his/her tonsils?			Does your youth wear glasses?		
Does your youth wear contacts?			Does your youth have a hearing aid?		
Does your youth have orthodontic devices?			Does your youth have any other oral devices?		
Swimming Ability:	<input type="checkbox"/> Beginner	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Advanced		
Any other information that would help youth and/or emergency staff:					
Reviewed by:	Reviewed by:	Reviewed by:	Youth 2009		
Date:	Date:	Date:			
Reviewed by:	Reviewed by:	Reviewed by:			
Date:	Date:	Date:			

