

## Medical Release/Permission to Treat Form

Name of Church: Thrasher United Methodist Church City/State: Vinton, VA

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Birthday: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Secondary Contact to notify in case of emergency: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Phone: \_\_\_\_\_

Please Supply ALL of the following information/Attach a copy of your insurance card.

Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Company's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Family Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physical Limitations: (Asthma, diabetes, allergies, etc.), and/or special instructions (Allergic to certain meds, rare blood type, wears contact lenses, etc.):

\_\_\_\_\_  
\_\_\_\_\_

List ALL medications taken on a regular basis. (Prescription meds MUST have a Pharmacy label and the name of doctor):

\_\_\_\_\_  
\_\_\_\_\_

List all operations/serious injuries and dates within the past five (5) years:

\_\_\_\_\_  
\_\_\_\_\_

I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge Thrasher UMC, and its staff, its members, and its affiliates from any and all claims, demands, actions or causes of action, past, present, or future arising out of any damage or injury while participating in activities with Thrasher UMC Youth

Emergency Authorization – I hereby give permission to medical personnel selected by the participant’s Church sponsor/his designee or event staff to order X-rays, routine tests, and treatment for myself. IN the event of an emergency and neither my primary contact nor secondary can be reached, I hereby give permission to the physician to selected by the Authorized Agent to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery to myself as named above.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release employees or agents from liability associated with participation in a church activity.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

The following to be completed by the notary witnessing the parent/guardian’s signature.

The state of \_\_\_\_\_ the county of \_\_\_\_\_

Before me, a Notary Public, on this day personally appeared \_\_\_\_\_

Know to me (or proved to me on the oath of \_\_\_\_\_) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_

\_\_\_\_\_  
Notary Public, State of \_\_\_\_\_

\_\_\_\_\_  
Print Name of Notary Public here

My commission expires the \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.