

**Providence United Methodist Church
2016-2017 Permission Form and Medical Agreement**

Child's name _____
(last) (first) (prefer to be called)

Birthdate _____
(month/day/year)

Home address _____
(street) (city) (state) (zip code)

Home phone _____ E-mail address _____

2016-17 School _____ Grade in School _____

Are you a member of PUMC? _____ If no, name of your church _____

*Your child's photo may be used (without names) in a newsletter or other social media, for Providence UMC. If you do NOT want your child's photo to be used, please initial here _____

IN CASE OF AN EMERGENCY CONTACT:

Parent(s)/Legal Guardian(s) _____
(circle one)

Day phone _____ Mobile phone _____

Evening phone _____ E-mail _____

ALTERNATE CONTACT:

Name _____ Daytime Phone _____

Evening Phone _____ Mobile Phone _____

Address _____ Relationship to Youth _____
(street) (city/state) (zip)

MEDICAL INFORMATION

Doctor's name _____ Phone _____

Dentist's name _____ Phone _____

Date of last Tetanus Shot _____ Medication(s) Youth may NOT take _____

**Medication(s) child/youth will be taking during an activity with Providence UMC should be sent with
Child/youth accompanied by written permission to administer (include dosage and time of day).**

Allergies and Special health concerns (i.e. special diet, disabilities) include:

please feel free to attach another page if necessary

PLEASE CONTINUE ON BACK...

Insurance Company _____ Phone _____

Address _____
(street) (city) (state) (zip code)

Policy # _____ Policy Holder's Identification # _____

**A NOTARY MUST BE PRESENT TO COMPLETE THIS SECTION.
DO NOT SIGN UNTIL IN THE PRESENCE OF A NOTARY.**

In the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation in a Providence United Methodist Church activity, every reasonable effort will be made to contact the persons listed on the reverse side of this page. If unsuccessful in contacting the persons listed, consent/permission is given for treatment by competent medical personnel.

Further, and unless specified otherwise, consent/permission is hereby given to all accompanying adult paid or volunteer leaders on this activity to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery (under advisement of qualified medical personnel). Preference consideration should be given to those adults in attendance from my church.

I agree that my insurance company will be used for such medical care expenses, and I am aware that the medical provider for any medical treatment expenses not cover by my insurance may bill me. I understand that if I do not have medical insurance coverage that I am responsible for the payment of any medical bills.

signature of parent or guardian relationship to youth

I, _____ a Notary Public for the State of North Carolina in
_____ County, do hereby certify that

_____ personally appeared before me this day and
acknowledged the due execution of the forgoing instrument.

Witness my hand and official seal this

_____ day of _____

2016 / 2017
(circle appropriate year)

Notary Public, signature

Notary Public, print

My Commission Expires _____