

Orange Park United Methodist Church- Children's Ministry

PARENTAL CONSENT AND MEDIA/MEDICAL AUTHORIZATION

THIS FORM IS REQUIRED FOR ALL YOUTH PARTICIPANTS AND MUST BE NOTARIZED!

Please Provide a Copy of the Front and Back of Your Insurance Card

Name of Child: _____ Grade: _____ DOB: _____

Parent(s)/Guardian(s): _____ (Father) _____ (Mother)

Address: _____
Street/Apt Number City State Zip Code

Parent/ Guardian Email: _____

Daytime Phone: _____ Evening Phone: _____

Parent/Guardian Cell: _____ Parent/Guardian Cell: _____

Emergency Contact: _____ Phone: _____ Relation: _____

As the parent (or legal guardian) of _____
Child's Name Printed

I understand that my child will be participating in activities during the period of September 1st, 2018- August 31st, 2019 which carry with them a certain degree of risk. Some of the activities may include swimming, running, hiking, sports, bowling and other activities of which will be offered. I consent for my child to participate in these activities.

Please indicate any restrictions on your child's activities:

_____ I represent that my child is physically fit and has the necessary skills to safely participate in these activities.

_____ I represent that my child has restrictions on the following particular activities: _____

_____ I understand and give consent for my child to travel to and from these events in transportation provided at times by volunteer drivers.

Media Release

I, _____, hereby give permission for the staff and volunteers of ORANGE PARK UNITED METHODIST CHURCH to photograph, videotape and/or voice tape my child/children for purposes of in-house church use and/or for public information for promotion of the church (i.e. brochures, websites, newspapers, radio, television).

Parent/Guardian Signature: _____ Date: _____

Medical Authorization

_____ It is my understanding that OPUMC will attempt to notify me in case of a medical emergency involving my child. If OPUMC cannot reach me, then I authorize the church to hire a doctor or health-care professional, and I give my permission to the doctor or other health-care professional, to provide the medical services he or she may deem necessary. I will pay for any medical expenses so incurred.

Allergies or other health considerations: _____

List any medications your child is taking: _____

Insurance Company: _____ Policy/Group #: _____

Signature of Father or Guardian _____ Date _____

Signature of Mother or Guardian _____ Date _____

*****State of Florida County of _____

Sworn to (or affirmed) and subscribed personally before me _____

this _____ day of _____, 20_____ by _____

NOTARY PUBLIC _____ Exp. Date _____ (SEAL)

Personally known: _____ OR Produced Identification _____ Type of Identification Produced _____