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

Daytime Phone: _____ Parent(s)/Guardian(s) Cell:_____

Evening Phone: _____ _____

Parent Email: _____

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 January 1st, 2017- December 31st, 2017 which carry with them a certain degree of risk. Some of the activities may include swimming, running, hiking, sports, bowling and other activities which the church may offer. 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 youth 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_____

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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_____