

**ASHLAND FIRST UNITED METHODIST CHURCH  
MEDICAL/PERMISSION FORM**

June 1, 2010 – May 31, 2011

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Medication Taken: \_\_\_\_\_

Allergies/Allergic Reactions: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Other Pertinent Health Information: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Last Date of Immunization: Tetanus \_\_\_\_\_ MMR #1 \_\_\_\_\_ MMR #2 \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

I, the undersigned parent or guardian, hereby authorize emergency medical, dental, health or hospital services be rendered to my child upon consent of an Ashland First United Methodist Church staff member or designated advisor.

The purpose of this authorization is to permit my child to receive emergency medical attention when needed while involved in activities connected with Ashland First United Methodist Church's Student Ministry when I or my emergency contact are unavailable to give consent.

This form also gives Ashland First United Methodist Church permission to use any photographs and/or video images of your child's likeness for purposes of (but not limited to) promotional materials, website design, and ministry recaps.

This authorization shall be effective from June 1, 2010 – May 31, 2011.

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

\_\_\_\_\_  
Date