RELEASE FORM

PARTICIPANT'S NAME_____BIRTHDAY_____

Purpose: This form enables parents and guardians to authorize the provision for emergency treatment for children who become ill or injured while at S1UMC events when parents or guardians cannot be contacted. Consent to seek such treatment is granted specifically to official representatives and chaperones of S1UMC.

TO GRANT CONSENT

NAME OF PARENT OF GUARDIAN_____

HOME ADDRESS_____

HOME TELEPHONE #_____

FATHER'S EMPLOYER_____PHONE #_____

MOTHER'S EMPLOYER_____PHONE #_____

REGULAR PHYSICIAN_____PHONE #_____

In the event that reasonable attempts to contact the above named have been unsuccessful, I hereby give my consent for any treatment deemed necessary for my son or daughter named on this form by a licensed physician.

PREFERRED HOSPITAL_____PHONE #_____

SIGNATURE OF PARENT OR GUARDIAN_____DATE_____

FAMILY INSURANCE COMPANY_____

POLICY #/GROUP #_____PATIENT #_____

If the parents cannot be reached, the alternate person to notify in the event of injury or illness is:

ALTERNATE CONTACT PERSON_____PHONE #_____

PARTICIPANT'S MOST RECENT MEDICAL HISTORY

SPECIAL DIET_____

ALLERGIES_____

CURRENT MEDICATION_____

PHYSICAL IMPAIRMENTS_____