Trinity United Methodist Church Student Information/Medical Release Form

Child / Student Full Name (Participant) _____

Birthdate (MM/DD/YY)_____Grade 2024-25_____School_____

Cell Phone _____Email (personal,not a school email)_____

_____

Home Address City State Zip

Parent Guardian #1 Information:

Name_____Cell Phone_____

_____

Home Address City State Zip

Parent/Guardian #2 Information:

Name_____Cell Phone_____

_____

Home Address City State Zip

Emergency Contact (not a parent/guardian):_____

Emergency Contact Phone #1_____Phone #2_____

CHILD/STUDENT LIABILITY RELEASE: In consideration of Trinity UMC allowing the Participant to participate in church & ministry activities, we (I), the undersigned, do hereby release, forever discharge and agree to hold harmless Trinity UMC, its directors, employees, volunteers and agents (collectively herein the "Church") from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child/youth Participant while involved in church & ministry activities. We (I) the parents(s) or legal guardian(s) of this Participant hereby grant our (my) permission for the Participant to participate fully in church & ministry activities, including trips away from the church premises. Furthermore, we (I) {and on behalf of our (my) minor-Participant(s)} hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein.

Further, authorization and permission is hereby given to said Church to furnish any necessary transportation, food and lodging for this Participant. The undersigned further hereby agree to hold harmless and indemnify said Church for any liability sustained by said Church as the result of the negligent, willful or intentional acts of said Participant, including expenses incurred attendant thereto.

STUDENT MEDICAL TREATMENT PERMISSION: We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any emergency x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital or emergency care facility. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned youth pursuant to this authorization.

CHILD/STUDENT MEDIA RELEASE: I/We understand and agree that photos, video, and sound clips of minors may be used for purposes of communication about the ministries of TUMC. Digital media may include the TUMC website (www.trinitymp.org), TUMC Facebook page, individual Facebook/Instagram accounts of Ministry Leaders and other adults working with minors, TUMC Facebook Group (closed group), TUMC Instagram, TUMC group email, TUMC e-newsletters and mailings. I/We have read and understand the TUMC Child/Youth Protection Policy.

STUDENT EARLY RETURN HOME POLICY: Should it be necessary for our (my) student to return home due to medical reasons, disciplinary action or otherwise, the undersigned shall assume all transportation costs and responsibility.

STUDENT TRANSPORTATION PERMISSION: The undersigned does also hereby give permission for our (my) student to ride in any vehicle driven by an approved ADULT chaperone while attending and participating in activities sponsored by TUMC.

The undersigned do(es) hereby give permission for our (my) child: _____ to attend and participate in Trinity UMC's (TUMC) church & ministry activities, events and retreats.

Parent/Guardian Signature _____Date_____

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Child/Student Medical Information

Alergies/Medications_____

Medications child/student should NOT take_____

Food Restrictions/Allergies _____

Special Needs (IEP, 504 plan etc)Yes/No, more explanation?_____

If this is for an overnight event, does medicine need to be given to student by a leader? Yes/No

If yes, please list name of medicine, amount and daily dosage:_____

Physician Name/Practice_____Physician Phone Number_____

Medical Insurance Provider_____

Policy Holder Name_____

Group/Plan #_____ID #_____

Medical Insurance Telephone Number_____

PLEASE ATTACH A COPY (FRONT AND BACK) OF MEDICAL INSURANCE CARD