

Last Name: \_\_\_\_\_ Grade: \_\_\_\_\_

**St. Luke United Methodist Church**  
**Information, Permission, and Medical Release Form**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
Last First Mid. Init.

Grade for 2011-2012 \_\_\_\_\_ School \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Relationship to student \_\_\_\_\_  
Last First Mid. Init.

Address \_\_\_\_\_  
Street City State Zip Code

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail \_\_\_\_\_

Contact in case of emergency (when parent/guardian cannot be reached):

Name \_\_\_\_\_ Relationship to student \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Home phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Medical Information**

Allergies \_\_\_\_\_ Date of last Tetanus Shot \_\_\_\_\_

Medications taken on a daily or regular basis \_\_\_\_\_

Special Health Problems or Concerns: \_\_\_\_\_

Insurance \_\_\_\_\_ Phone Number \_\_\_\_\_

Policy Number \_\_\_\_\_ Policy Holder's ID # \_\_\_\_\_

Physician \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

Dentist \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

**Attach a copy of the front and back of your insurance card**

**Permissions**

I do hereby certify that my child, \_\_\_\_\_, has permission to participate:

In all trips planned by St. Luke UMC from August 28, 2011 to August 31, 2012     \_\_\_yes \_\_\_no

In church newsletter, television, or newspaper photographs                     \_\_\_yes \_\_\_no

In photographs on the church website (student’s name would not be used)     \_\_\_yes \_\_\_no

I understand that it is the expectation of St. Luke UMC that my child will remain for the duration of the scheduled event unless they, or their parents, notify the adult leadership of the event.

In the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation with St. Luke United Methodist Church, every reasonable effort will be made to contact the persons listed on the reverse side. If unsuccessful in contacting the persons listed, consent/permission is given for treatment by competent medical personnel.

I understand that St. Luke United Methodist Church does not carry accident or medical insurance on participants or volunteers. I agree that my insurance company will be used for such medical care expenses. I am aware that I may be billed by the medical provider for any medical treatment expenses not covered by my insurance and that I am responsible for the payment of any medical bills.

***Please sign below in the presence of a Notary Public.***

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Date signed

Personally appeared before me, \_\_\_\_\_  
A Notary Public of \_\_\_\_\_ County in the State of \_\_\_\_\_  
The persons whose signatures appear above and with whom I am personally acquainted and  
acknowledge that he/she executed the within instrument for the purposes therein contained.

Witness my hand and official seal this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_