# Park Memorial United Methodist Church

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**Park Memorial UMC Children's Ministry**
**Medical Release Form**

Full Name_____ Grade _____
Birthdate (mm/dd/yyyy)____/____/_____
Address (NO PO Boxes please)_____
City_____ State_____ Zip_____ Grade_____
Parent/Legal Guardian Information
Name_____ Phone (home/cell) _____ (work)_____
E-mail_____ Best way to contact?
Emergency Contact Information:
Name _____ Relationship _____
Phone_____
Name _____ Relationship _____
Phone_____
Medical Information:
Physician_____ Office Phone_____
Allergies (i.e. Penicillin, Poison Ivy, Bee Stings, etc.)
_____
Need to know Information
Date of last Tetanus Shot_____ Other Immunizations_____
_____ _____
Helpful Information_____
_____

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**Children's Ministry Permission Form**

I (We) give permission for our child (print name)_____ to participate with the Park Memorial United Methodist Church of Jeffersonville, IN.

_____
Parent/Legal Guardian Printed Name
_____ Date (mm/dd/yyyy)____/____/_____
Parent/Legal Guardian Signature

Consent for Treatment:
I (We) hereby give permission and written consent to the hospital selected by the Park Memorial United Methodist Church Children's Ministry (paid church staff and/or volunteer adult leaders) to provide any medical treatment and/or surgical treatment to our child (print name)_____as deemed necessary for the care of any injury or illness.

_____
Parent/Legal Guardian Printed Name
_____ Date (mm/dd/yyyy)____/____/_____
Parent/Legal Guardian Signature