Student Medical Emergency Release Form (S.M.E.R.F)

Elizabeth Presbyterian Church/325 S Banner St./Elizabeth, CO 80107

By filling out and signing this form, you give permission for your child to participate in programs or activities authorized by and carried out under supervision of the Youth Ministry of Elizabeth Presbyterian Church for the time period of **Sept. 1, 2010** *to* **Aug. 31th, 2011**. *You also authorize any emergency medical treatment necessary as a result of participation in the programs or activities.*

I, _____ the parent/guardian of _____ (date of birth) _____ Grade ___ School _____, give permission for my child to participate in the Elizabeth Presbyterian Youth Group programs and activities for the time period of **Sept 1, 2010** to **Aug 31st, 2011** and accept full responsibility for my child's participation. I also authorize and consent to any emergency X-ray examination, medical diagnosis or treatment that may be necessary, provided it shall be under the general or special supervision and on the advice of our family physician or, it if is not practical to reach our family physician, any nurse, emergency medical technician, or physician licensed to practice medicine. I release the volunteers and staff of Elizabeth Presbyterian Church from responsibility and liability for any illness, injury, harm or loss, during approved activities. My child has my permission to be transported to and from activities in vehicles driven by approved volunteers and staff members.

Parent/Guardian #1 Information

Name _____
Relationship _____
Home Phone _____ Work _____
Cell Phone _____
Email _____
Address _____
_____
Does child reside with Guardian #1 _____

Parent/Guardian #2 Information

Name _____
Relationship _____
Home Phone _____ Work _____
Cell Phone _____
Email _____
Address_____
_____
Does child reside with Guardian #2 _____

Alternate person to contact if I cannot be reached, relationship to youth and their phone :
Name _____ Relationship _____ Phone _____

Medical/Health Insurance Company : _____
Policy # : _____ **Group #:** _____
Family Physician : _____ **Phone # :** _____

Additional comments regarding medical history, necessary medications, allergies, penicillin or drug reactions, etc. which may be needed in any treatment:

_____
_____
_____

Signature of Youth Participant _____ Date _____

Signature of Parent or legal guardian _____ Date _____

I give my permission for my youth's picture to be taken as a part of the youth ministry activities and to be used in any promotion of EPC's youth activities including the website. Initial _____