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*Student's Name*

**First United Methodist Church**  
301 Church St.  
Sulphur Springs, TX 75482  
(903) 885-2185

## **HEALTH & RELEASE FORM**

During the period of August 1, 2018 through September 1, 2019, *the above named student* will participate in student activities sponsored by **First United Methodist Church of Sulphur Springs, TX**.

For the above listed dates, in which this form is effective, the undersigned parent/guardian of the above written minor child, authorizes the sponsors in charge of any **First United Methodist Church of Sulphur Springs, TX** activity to such medical treatment and/or hospital care as may be deemed necessary by a licensed physician for the above mentioned minor. This authorization includes consent to any examination, medical diagnosis, treatment, or hospital care, including drugs under an emergency situation, in order to preserve the health or life of said minor child. This authorization is effective August 1, 2018 and shall continue until September 1, 2019. The undersigned further releases the **First United Methodist Church of Sulphur Springs, TX and it's sponsors** from any and all liability which may result from sickness or injury to the minor child while on a First United Methodist Church of Sulphur Springs, TX sponsored trip or activity.

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*Parent/Guardian Signature*

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*Date*

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**MEDICAL INFORMATION**

Medication my child takes at this time: \_\_\_\_\_

For the following reasons: \_\_\_\_\_

My child is allergic to the following medications: \_\_\_\_\_

Date of last Tetanus Shot (should be current): \_\_\_\_\_

My child has the following physical and/or medical conditions which the sponsor and or a physician should know about. (Please list allergies, physical and/or medical conditions, etc.):

**IN CASE OF EMERGENCY, NOTIFY (please print)**

1. \_\_\_\_\_ Relationship \_\_\_\_\_

Phone :Home: \_\_\_\_\_ Cell: \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_

Phone :Home: \_\_\_\_\_ Cell: \_\_\_\_\_

**PHYSICIAN**

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Other Insurance Information: \_\_\_\_\_

*Please attach a copy of your current insurance card.*

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