CONSENT TO MEDICAL TREATMENT AND SERVICES

MAPLES MEMORIAL UNITED METHODIST CHURCH YOUTH MINISTRY

8745 Goodman Rd., Olive Branch, MS 38654

(662) 895-2279

Effective August 1, 2017-July 31st, 2018

This will certify that I, the undersigned, _____ consent and grant permission to Maples Memorial United Methodist Church and its adult leaders to render First Aid if the need should arise. In the event of an emergency, I also give permission to the physician or other medical staff, selected by the adult leader in charge, to hospitalize, secure proper anesthesia, order injection, or secure other medical or surgical treatment, as needed. This includes but is not limited to the administration of anesthetic, laboratory procedures, medical or surgical treatment, X-ray examination, or other hospital service.

Release of Maples Memorial United Methodist Church in Olive Branch, Mississippi:

I, the undersigned, _____ shall indemnify, hold free and harmless, assume liability for, and defend Maples Memorial United Methodist Church in Olive Branch, Mississippi, its agents, employees, officers, and directors from any and all expenses including but not limited to attorney's fees, reasonable investigation and discovery costs, court costs, and all other sums which Maples Memorial United Methodist Church, assertion of liability, or any claim or action founded thereon, arising or alleged to have risen out of my use of real or personal property belonging to Maples Memorial United Methodist Church, its agents, employees, officers, and directors, or by omission by myself.

Signature _____

PERSONAL INFO

Name: (First)_____(Middle)_____(Last)_____

Preferred Name:_____

Date of Birth:_____

Address:_____

Cell:_____

E-mail:_____

Do we have your permission to post pictures of you on various forms of social media from youth events? **Yes**_____ **No**_____

Continued On Other Side

EMERGENCY INFO

In the event of an emergency, please contact the following:

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

MEDICAL INFO

*****PLEASE ATTACH A COPY OF YOUR INSURANCE CARD TO THIS FORM*****

Insurance Company_____

Policy Number_____

Policy Holder's Name_____

Signature _____

Address of Policy Holder _____

E-mail of Policy Holder _____

Allergies or Medical Conditions (Current Medications)_____

_____

_____

Is there anything else we need to know that may impact your ability to participate in youth activities?

_____

_____

County of _____

Before me, a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared _____, who acknowledges execution of this document on this ____ day of _____, 20____.

My commission expires:_____ _____

Notary Public's Signature

Notary Stamp