

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) _____

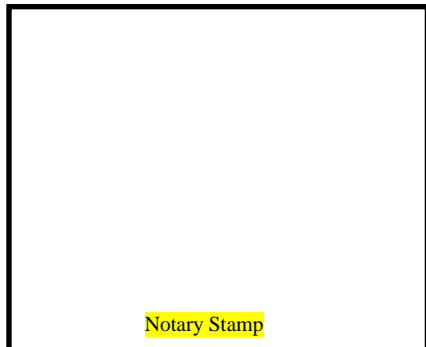
Is there anything else we need to know that may impact your ability to participate in youth activities?

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