

MEDICAL & LIABILITY RELEASE FORM

SMALL CHURCH SUMMIT 2018

PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO FUMC GATESVILLE ON SEPT. 15

I, _____, consent to allow _____
Print Name of Parent/Guardian *Print Name of Child(ren)*

to be transported from First United Methodist Church to Coryell Memorial Hospital in the event of an emergency. I hereby authorize any hospital, clinic, physician, doctor, nurse, or technician to furnish my child, named above, any medical care treatment necessary as a result of injuries sustained or other emergency medical treatment as the circumstances require while being in the care of the nursery. I hereby authorize a representative of First United Methodist Church to retain or acquire said medical care and treatment on my behalf if I cannot be reached by telephone or there is not time or opportunity to make a phone call. I agree not to hold such a person responsible for any damages arising from the giving of such consent.

Parent/Guardian Signature

Date

Medical Insurance Co: _____ **Policy#** _____

Primary Physician: _____ **Phone:** _____

Hospital Preference: _____

PLEASE PROVIDE A COPY OF YOUR CHILD'S INSURANCE CARD (FRONT AND BACK).

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Please list the Name(s) of the Child(ren) and their Date(s) of Birth below:

Parent/Legal Guardian's Name: _____ **Phone** _____

Emergency Contact Name: _____ **Phone** _____

Allergies: _____

Special Notes: _____

