



FIRST UNITED METHODIST CHURCH CLEBURNE

Information and Release Form

(For students and kids)

Name: _____ Birthdate: _____

Address: _____

Cell: _____ Other Phone: _____

In case of emergency, contact the following:

Name: _____ Birthdate: _____

Address: _____

Cell: _____ Other Phone: _____

Basic Medical Info:

Known food or medicinal allergies:

Significant medical history:

Current medications:

Health Insurance Company:

Policy #: _____ Group #: _____

Name of policy holder: _____

Doctor: _____ Phone: _____

I, _____, authorize (trip participant) _____
(another adult on the trip)

If I am unable to do so, to consent to any necessary examination, anesthetic, medical diagnosis, surgery treatment and/or hospital care rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which he/she practices, during the duration of the trip identified below.

- 1. I HEREBY RELEASE AND FOREVER DISCHARGE THE CHURCH AND ALL OF ITS REPRESENTATIVES, AGENTS, ATTORNEYS, PRINCIPALS, EMPLOYEES, OFFICERS, DIRECTORS, PARTNERS, VOLUNTEERS, PARENTS, SUBSIDIARIES, AFFILIATES, SUCCESSORS, HEIRS AND ASSIGNS (The "church") FROM ANY AND ALL ACTIONS, CAUSES OF ACTION, LIABILITIES, SUITS, DEBTS, CLAIMS OR DEMANDS FOR ANY LOSS ARISING FROM MY PARTICIPATION IN A FUNCTION; and,**
- 2. ON BEHALF OF MYSELF AND ANY OF MY REPRESENTATIVES, AGENTS, ATTORNEYS, PRINCIPALS, EMPLOYEES, OFFICERS, DIRECTORS, PARTNERS, VOLUNTEERS, PARENTS, SUBSIDIARIES, AFFILIATES, SUCCESSORS, HEIRS AND ASSIGNS, I AGREE TO INDEMNIFY AND HOLD HARMLESS THE CHURCH FROM ALL CLAIMS AND CAUSES OF ACTION ARISING FROM MY PARTICIPATION IN A FUNCTION; and**
3. I will be responsible to pay for any medical costs incurred on the trip identified below. It is my sole responsibility to seek coverage from my own insurer, if any, and I remain responsible for such costs regardless of insurance coverage or denial.

Trip: _____ Dates: _____

Signature of Parent or Guardian: _____