

Shady Grove United Methodist Church
2018-2019 Medical Release, Consent and Conduct Form

Page 1 of 2 – Please Complete Back Side

I, _____, am the parent/legal guardian
Name of parent or guardian
of _____, Hereinafter, "my child", who
Name of minor
was born on _____, _____. My child is attending and participating in activities with Shady Grove United Methodist church, located at 4825 Pouncey Tract Road, Glen Allen, VA 23059.

I hereby authorize Frank Basil or another Shady Grove UMC officers, agents, servants, or employees who are 18 years of age or older, who supervise activities at Shady Grove UMC into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment or hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize Frank Basil, or other SGUMC officers, agents, servants, or employees who are 18 years of age or older, who supervise the activities at Shady Grove UMC to receive physical custody of my child, upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to SGUMC agents named above plus officers, agents, servants, or employees who are 18 years of age or older who supervise activities at Shady Grove UMC.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, to exercise his/her best judgment on what is advisable for my child's care, upon advice of such physician, dentist, and surgeon.

Dated _____

Signature of parent or legal guardian

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All information is kept confidential and only shared with medical professionals and adult leaders that may need to know for the purpose of treatment or to administer basic first aid or care.

Student Name

Cell Phone

Street Address

City State Zip

Parent/Guardian Name

Work phone

Cell phone

Parent/Guardian Name

Work phone

Cell phone

Attach Copy of Insurance Card

Emergency Contact

Phone

Relationship to minor

Name of family physician

Phone-family physician

Medicine being taken by my child

Date of last tetanus shot

Allergies/allergic reactions(food, medicine, seasonal, etc.) and **intolerances**(gluten, lactose, etc.) and Other information and treatment for allergies/intolerances that an adult leader or doctor should know(Epipen, use Benadryl only, anxiety, etc.)

For your information, we expect each student to conform to these rules of conduct:

- No possession or use of alcohol, drugs, or tobacco
- No fighting, weapons, fireworks, lighters, or explosives
- Wear appropriate clothing (must adhere to stated clothing policy for specific offsite activities)
- No boys in girls' sleeping rooms and no girls in boys' sleeping rooms
- Students may NOT drive on trips, offsite events, etc.
- Respect property, staff, adult leaders and all participants
- Respect and comply with event schedules
- Respect and comply with cell phone guidelines (some activities may not allow cell phones)
- Participation with the group is expected

Students who fail to comply with these expectations may be sent home at their parents' expense.

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Student Signature

Date