

**NAME OF CHILD** \_\_\_\_\_

**Grade** \_\_\_\_\_

**Gender**    **M**    **F**

**HEALTH STATEMENT** ... Please fill this out in order that we might be more fully aware of your child's special needs and facilitate any medical attention that might be required while in Children's programming.

|   |  |
|---|--|
| Parent or Guardian Name _____   | Home Telephone Number with Area Code _____ |
| Full Mailing Address _____  |  |
| <b>TELEPHONE NUMBERS TO BE USED IN CASE OF EMERGENCY</b>  |  |
| Name and Work Telephone Numbers with area code: _____   |  |
| Name and Cell Phone Numbers: _____  |  |
| Emergency Contact Name and Cell Phone Number <b>other than a parent</b> : _____   |  |
| Physician's Name _____  | Physician's Telephone Number _____         |
| Dentist's Name _____  | Dentist's Telephone Number _____           |
| <b>ALLERGIES</b> Asthma <input type="checkbox"/> Tetanus Shots <input type="checkbox"/> Penicillin <input type="checkbox"/> Hay Fever <input type="checkbox"/> Sulfa or other <input type="checkbox"/> Poison Ivy/Oak <input type="checkbox"/><br>Bee or insect Sting <input type="checkbox"/> Food Allergies <input type="checkbox"/> (please specify) _____<br>Other (please specify) _____ |  |

**MEDICAL/DENTAL/LIABILITY RELEASE**

I/We, the undersigned, are the parents having legal custody, or the legal guardians of the children named on this form, minors, and have given our consent for them to participate in Children's Ministry programming at Williamson's Chapel UMC. I/We understand that there are inherent risks involved in any program and I/we hereby release Williamson's Chapel UMC, its employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement with Children's Ministry. In the event that s/he is injured while attending our programs and requires the attention of a physician/dentist, I/we consent to any reasonable treatment as deemed necessary by a licensed physician/dentist. In the event treatment is required which a dentist, physician, and/or hospital personnel refuses to administer without my/our consent, I/we hereby authorize the Williamson's Chapel UMC staff, or another adult leader designated by the staff, to give consent for me/us, and I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician or dentist. I/We also acknowledge that we will ultimately be responsible for the cost of any medical/dental care should the cost of that medical or dental care not be reimbursed by the insurance provider. Further, I/we affirm that the insurance information provided above is accurate at this date and will, to the best of my knowledge, still be in force for the duration of this year.

Initials: \_\_\_\_\_

**BEHAVIOR EXPECTATIONS**

I/We understand that Williamson's Chapel UMC Children's Ministry expects all participants to behave in a respectful manner towards the adults in leadership, their peers and the property of this congregation. Children who choose to act disrespectfully will receive a warning; followed by conversations with his or her parents/guardians should the behavior continue. In the event that this disrespectful behavior does not desist, I/we understand that the child's parents/guardians will be requested to accompany the child during Children's Ministry programming.

Initials: \_\_\_\_\_

**IMAGE RELEASE**

I permit my child to be included in photographs and videos that may be used for display in Williamson's Chapel UMC informational and promotional publications, including the Williamson's Chapel website. I understand that no reference to my child's name will be made alongside such images and that I will not receive compensation for the use of these images.

Initials: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**THE FOLLOWING INFORMATION IS NECESSARY SHOULD YOUR CHILD NEED TREATMENT**

**\*\*\* PLEASE NOTIFY US IF INSURANCE INFORMATION CHANGES DURING THE YEAR \*\*\***

|   |       |
|---|-------|
| Name of Child                           | _____ |
| Date of Birth                           | _____ |
| Health Insurance Policy Name and Number | _____ |
| Dental Insurance Policy Name and Number | _____ |

\*\*You must attach a copy of the front and back of your insurance card