



MEDICAL AUTHORIZATION AND IMAGE RELEASE FORM FOR MINORS

CONSENT TO MEDICAL TREATMENT OF MINOR AND RELEASE OF LIABILITY CONSENT TO BE PHOTOGRAPHED AND RELEASE FOR USE BY ST ANDREW (ONLINE OR IN PRINTED MATERIALS)

_____ has my/our permission to go on retreats, trips, and other offsite events in conjunction with St. Andrew Methodist Church. Please seek any medical assistance needed while he/she is with this group, including administration of First Aid and over-the-counter medications by St. Andrew staff or volunteers. We _____, parent(s) or guardian(s) of _____, a minor, do hereby authorize adult workers with St. Andrew Methodist Church of Plano, agents for undersigned, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff or licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. I also agree to pay for all charges associated with the care of my child. I knowingly release, absolve, indemnity and hold harmless St. Andrew Methodist Church and its agents and employees from all claims that might result from any injury or death of any minor.

We _____, parent(s) or guardian(s) of _____, a minor, grant St. Andrew Methodist Church permission to use photographs from St. Andrew Methodist events for any legal use, including but not limited to: publicity, illustration, advertising, and web content.

I/We have read and understand the above document. By signing this document, I hereby release St. Andrew Methodist Church of Plano from any and all liability for personal injury or damage to property.

Print Name: _____ Date: _____

Parent/Guardian Signature: _____ Relationship to Minor: _____

NOTARY REQUIRED

COUNTY OF: _____

Before me, the undersigned authority, on this day personally appeared, _____ known to me to be the person whose name is subscribed above and acknowledged to me that s/he executed the same for the sworn purpose therein expressed.

Given under my hand and seal of this office this _____ day of _____, 20____.

STATE OF TEXAS _____

My Commission Expires: _____



Participant Name: _____

Participant Cell Phone: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Home Phone Number: _____

Gender: _____

Age: _____

Date of Birth: _____

Emergency Contact 1 Name: _____

Contact 1 Phone Number: _____

Emergency Contact 2 Name: _____

Contact 2 Phone Number: _____

Participant's Physician: _____

Physician's Phone Number: _____

Health Insurance Provider: _____

Policy/Group Number: _____

Subscriber/ID Number: _____

Known Allergies: _____

List ALL health conditions or restrictions.

List any physical limitations.

List ALL medications to be taken, including over-the-counter medications, with dosage and timing. All medication must be sent in original containers.

Select one of the following:

- This camper has received all vaccinations required to attend public school (age-appropriate doses of TDap, Polio, MMR, Hepatitis A, Hepatitis B, Varicella, Meningococcal)
- This camper has not been vaccinated due to a religious or personal belief or medical necessity.

Please select any over-the-counter medications that you do NOT want your child to receive:

Acetaminophen Ibuprofen Benadryl Cortisone Cream Narcan