



United Methodist Church Thousand Oaks Youth Medical Information and Release

Name: _____ Date of Birth _____

Address: _____
Street City State Zip

School: _____ High School Grad Year: _____

Parent(s) Name(s): _____

Home Phone: _____ Parent Cell Phone _____

Youth Cell Phone (if applicable): _____

E-Mail Address (Youth): _____

Parent(s) E-mail Address(es): _____

Emergency Contact: _____
Name Phone Relation

Medical Information

Health Insurance Company and Policy #: _____

Medications/Medical Concerns: _____

In emergency situations where I cannot be contacted, I hereby authorize the youth director, pastor, and/or adult supervision to follow the procedures below:

- To have made reasonable attempts to contact parents, guardians, or named agents.
- To be my agent to give consent to any X-ray examination, anesthetic, medical, or surgical diagnosis/ treatment, and hospital care which is felt necessary for the life or well-being of my child by any licensed physician, medical response team, or surgeon.

Signature: _____
Parent/Guardian Date

- When parents, guardians, or named agents cannot be contacted, the youth director, pastor, and/or adult in supervision will contact the following service provider:

Family Doctor: _____
Name Phone