

GUMY Student Health Waiver and Authorization

Youth will not be allowed to participate in church events without a current version of this completed form being on file. Youth with special needs are encouraged to contact a youth staff member before coming to the event.

Student Information

Name: _____ Grade for **2020-21**: _____
D.O.B.: _____ Cell Phone: _____ Home Phone: _____
Address: _____ Email: _____

Parent/Guardian – Emergency Information

Father's/Guardian's Name: _____
Work Phone: _____ Cell Phone: _____ Home Phone: _____
Address: _____ Email: _____

Mother's/Guardian's Name: _____
Work Phone: _____ Cell Phone: _____ Home Phone: _____
Address: _____ Email: _____

Emergency Contact's Name: _____ Relation: _____
Work Phone: _____ Cell Phone: _____ Home Phone: _____

Medical Insurance Information

Insured Name: _____
Insurance Company and Policy Number: _____
Doctor's Name and Phone Number: _____
Hospital of Choice: _____
Current on tetanus vaccination: Yes No If yes, date received: _____

******* Please check the area that applies so the youth staff can meet your student's needs *******

<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other Allergies
<input type="checkbox"/> Daily Meds	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Fainting
<input type="checkbox"/> Bee Sting Allergy	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Contacts	<input type="checkbox"/> Seizures	<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Other Health Problem (attach)

Medication: Please list prescription, dosage and frequency. Please send medication required during a youth event in separate containers in a plastic bag clearly labeled with the individual's name on it.

- 1.
- 2.
- 3.

I give a youth staff member permission to administer over-the-counter medications for those items checked below in the event that it becomes necessary. Dosages will be administered according to the instructions on the bottle only unless a physician directs otherwise.

<input type="checkbox"/> Antacids	<input type="checkbox"/> Cough Medicine/Drops	<input type="checkbox"/> Benadryl	<input type="checkbox"/> Tylenol/acetaminophen	<input type="checkbox"/> Advil/ibuprofen
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sudafed	<input type="checkbox"/> Neosporin		

Allergies and food restrictions: Please list any and all allergies that a doctor should know about in case of emergency

Physical Restrictions: Please list any and all physical restrictions or conditions that restrict activity for your student



Authorizations and Waiver

I, the undersigned, being the parent/guardian legally authorized on behalf of _____, a minor child (herein "Minor"), in consideration of the opportunity for said Minor to participate in the activities of the Great Plains Annual Conference of the United Methodist Church, Inc., its Churches and related entities and Program Activities (herein "Church") do:

1. In the event of any injury or medical emergency affecting said Minor, authorize and grant to the Church and anyone acting on behalf of the Church the right to provide, approve, seek and obtain medical care, treatment and assistance for said Minor, and
2. Do give the Church my permission to use said Minor's image publicly to promote the activities of the Church. The images may be used in print publications, online publications, presentations, websites, and social media. I understand that no royalty, fee or other compensation shall become payable to me because of such use, and
3. Waive any and all claims of the said Minor or anyone claiming through said Minor against the Church arising out of said activities.

I understand this document has significant legal consequences, but I also believe the Minor child will benefit from the activities of the Church, and, for that reason and in consideration of said benefit; I choose to execute this Authorization and Waiver. I also understand this Authorization and Waiver will be in effect from June 1, 2020 through August 31, 2021.

(Signature of Parent/Guardian)

STATE OF

COUNTY OF

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

Sworn before me this _____ day of _____, _____.

(Signature of Notary Public)

My Commission Expires:

(seal)

