First United Methodist Church of Dothan
Student Ministry Medical Form

First United Methodist Church, Inc.

STATE OF ALABAMA COUNTY OF HOUSTON

BEFORE ME, the undersigned Notary Public, personally appeared (Parent's Name) _________________________ who after being duly sworn say as follows:

Affiant(s) is/are the parent(s)/guardian(s) of _______________________("child") and as such do hereby understand that the First United Methodist Church of Dothan, AL, ("Church") does not provide accident insurance and affiant shall assume all financial obligations due to an accident, injury, or illness of child. Affiant hereby grants permission for the child to receive any and all necessary medical treatment in the event of an injury or illness as a result of his/her participation as may be determined by an authorized medical doctor. Affiant does hereby designate Church's staff member, Brad Price and/or any other adult counselors in attendance as affiant's attorneys in fact for the purpose of arranging for and consenting to medical, therapeutically, and surgical procedures for the child, including administration of drugs pursuant to Section 26-1-1, et seq., Code of Alabama and Section 22-8-1, et seq., Code of Alabama for the calendar year 20___. In consideration of the foregoing, affiant for themselves and said child do hereby agree to indemnity and save harmless Church against any claim for damages, compensation or other action by reason of the exercise of (1) this power of attorney, including costs and attorney's fees or (2) the attendance by this child of this event.

Affiant states that the following is true and correct:

Name of INS. Company ____

Insurance Company's Address____

City ______________________________ State ___________ Zip ______________

Name of Subscriber ____

Relationship to Participant ____

Policy Number ____

Doctor ________________________________ Doctor's Phone Number ________________________

Mother's Name_________________________________Father's Name______________________________

Parent's Home Phone ____________________ Work Phone: Mom ______________ Dad______________

Cell: Mom___________________ Dad_________________

Email: Mom___________________________________ Dad_______________________________________

If unable to reach me, contact the following:

Name ____

Relation ____________________________ Phone Number _____________________________

Additional Info on the Back of This Form

MEDICAL INFORMATION

Natural allergies (bee stings, dust, etc.): ____

Allergies to medication: ____

Any known medical problems we should be aware of _______________________________________

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Any other information we might need.(blood type, contacts, etc.)_____________________________

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____ State of _____________________________

Parent / Guardian Signature

Address: _____________________________ County of _____________________________

_____________________________ This _______ day of ___________________,

_____________________________ 20 ____.

Phone: _____________________________

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NOTARY PUBLIC