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, Robbie Amunds 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 _____

_____

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

_____

_____

_____

Parent / Guardian Signature

Address: _____

_____

_____

Phone: _____

This form must be notarized by a notary public. You must sign the form in the presence of the notary.

State of _____

County of_____

This _____ day of _____,

20_____

_____

NOTARY PUBLIC'S SIGNATURE