

**Children's Ministries Medical Release Form**  
**Mt. Sylvan United Methodist Church**  
**5731 Roxboro Road, Durham, NC 27712**  
**Phone 919-471-0032 / Fax 919-479-7330**

Effective Date: September 1, 2011 – September 1, 2012

Information on this form is carried on all outings. In case of an emergency, illness, or accident, parents/guardians will be contacted at the earliest possible moment. In the event we cannot reach you immediately, we need permission for emergency medical care. Please fill out both sides of this form completely, so that information is available for health care providers if medical care is necessary.

In the event [print child(children)'s full name(s)] \_\_\_\_\_

\_\_\_\_\_ suffers an illness or accident requiring emergency treatment, hospitalization, medication, or surgery while participating in activities of Mt. Sylvan UMC, I hereby authorize any necessary treatment, hospitalization, medication, or surgery recommended by a licensed physician and approved by the person in charge of the children's activity. By my signature, health information deemed necessary by a physician for the attending adult to make such a decision is released in accordance with HIPAA guidelines.

\_\_\_\_\_ Print Mother/Guardian's name                      \_\_\_\_\_ Print Father/Guardian's name

\_\_\_\_\_ Parent/Guardian's signature                      \_\_\_\_\_ Date

Child's Physician/Pediatrician \_\_\_\_\_  
Name and phone number

Child #1 Soc. Sec. # \_\_\_\_\_ Child#1 birthdate \_\_\_\_\_

Child #2 Soc. Sec. # \_\_\_\_\_ Child#2 birthdate \_\_\_\_\_

Child #3 Soc. Sec. # \_\_\_\_\_ Child #3 birthdate \_\_\_\_\_

Child's Address \_\_\_\_\_

**Parent/Guardian Contact Information**

Mother's Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
(or maternal guardian)

Father's Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
(or paternal guardian)

In case neither parent/guardian can be reached, contact

name \_\_\_\_\_ relationship \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

## Medical Insurance Information

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

## Chronic Illnesses/Restrictions

Please write none if not applicable

## Allergies

List all allergies and reactions. Please write none if not applicable.

## Prescription Medication Information

Please list name of medication, dosage, and frequency. Please write none if not applicable

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Do not write below this line

State of North Carolina

Durham County

I, \_\_\_\_\_, Notary Public of Durham County, do

hereby certify that \_\_\_\_\_, appeared before me this day and

acknowledged the due execution of the foregoing instrument in writing.

Witness my hand and seal, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

My Commission Expires: \_\_\_\_\_

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Notary Public

(Stamp/Seal)