

SPACE for GRACE: Youth Ministry of Kent UMC

Registration & Consent Form :2009-2010

YOUTH INFORMATION:

Last Name	First Name	Grade & School
Home Phone	Mobile Phone	Date of Birth
Home Address		E-mail Address

PARENT/GUARDIAN INFORMATION:

Name(s):	E-mail: (is e-mail a good way to contact you? ___yes ___no)
Day Phone	Evening Phone
DRIVERS: Please list drivers who have permission to pick-up your son/daughter.	

YOUTH HEALTH INFORMATION: *required* for attending any activity when the parent/guardian is not present

Medications: list regular medications and proper dosage		Special Needs/Situations: If your son/daughter has any physical, emotional, or medical limitations, please inform us so our leaders can provide appropriate support
Medical Insurance: Company _____ Group # _____ Policy Number _____	Immunizations: Are the immunizations required for school current? ___yes ___no Date of last tetanus: _____ Blood type (if known): _____	
Allergies/Sensitivities:	Family Physician: Name: _____ Phone: _____	

EMERGENCY CONTACT: (someone who does not live with your child)

NAME(s) & Relation	Phone
NAME(s) & Relation	Phone

Consent for Participation, Transportation, and Emergency Care

The undersigned do (does) hereby give permission for our (my) child, _____, to attend and participate in activities sponsored by the Kent United Methodist Youth Ministry between the dates of September 1, 2009 and October 1, 2010.

____ INITIAL

____ INITIAL

The undersigned do (does) hereby give permission for our (my) child, _____, to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by KUMC.

____ INITIAL

____ INITIAL

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Parent/Guardian Name _____ Date _____

Signature _____

Parent/Guardian Name _____ Date _____

Signature _____