

# Kent United Methodist Church

## Youth Ministries Consent Form: 2007-2008

11010 SE 248th Street, Kent, WA 98030  
 Senior Pastor: Rev. Dr. Keat Yeoh

Phone: 253-852-3900 Fax: 253-520-0093  
 Director of Youth Ministries: Ali Box

### Youth Information

<b>Last Name</b>	<b>Home Phone</b>	<b>Grade &amp; School</b>
<b>First Name</b>	<b>Mobile Phone</b>	<b>Date of Birth</b>
<b>Home Address</b>		<b>E-mail Address</b>

### Medical Information *(required for activities other than Sunday AM classes)*

<b>Medications</b> - List all regular medications and proper dosage.		<b>Special Needs/Situations</b> - If your youth has any physical, emotional, or medical limitations, please inform us to help the leaders provide appropriate support.
<b>Insurance Company:</b>  Group #:  Policy #:	<b>Immunizations</b> <i>Are immunizations needed for school current? ___yes ___no</i> <i>Date of last tetanus shot:</i>  <i>Blood Type (if known):</i>	
<b>Allergies/Sensitivities:</b>	<b>Family Physician</b> Name:  Phone:	

### Parent/Guardian Information

<b>Name(s)</b>	<b>Day Phone</b>
<b>Evening Phone</b>	<b>E-mail</b>

The following people have permission pick-up my child from KUMC Youth Events:

\*Please list anyone who should NOT be allowed to pick-up your child (if any):

## **Consent for Participation, Transportation, and Emergency Care**

The undersigned does hereby give permission for **our (my)child**

\_\_\_\_\_ to attend and participate in activities sponsored by the Kent United Methodist Church (KUMC) Youth Ministries between the dates of **September 1, 2007 - Oct 1, 2008.**

The undersigned 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.

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 the 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 \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Emergency Contact Information:** Someone who does not live with the child and someone out of the area (Friend, Neighbor, Grandparent, etc.)

Name/Relation	Phone
Name/Relation	Phone