Plainfield United Methodist Church ▪ Junior/Senior High Youth Ministries
General Permission ▪ Liability Waiver ▪ Code of Conduct ▪ Medical Release

Youth Name(s): ____ Phone ________________

School/City/Grade: ____

Parent/Guardian: ____ Phone ________________

Address: ____

Emergency Contact: ____ Phone ________________
(other than parent) (relation to youth)

General Consent & Permission ▪ Liability Waiver

I, the undersigned, am the legal parent/guardian of the minor youth named above ("youth") and give consent for him/her/them to attend and travel to and from events being organized by Plainfield United Methodist Church ("PUMC"). According to the "Safe Sanctuaries" Policy, I grant written permission to allow my youth to travel with one qualified driver. I agree that PUMC shall have the right to use the image and likeness (including caricature) of my youth for PUMC's website and for any other materials used for PUMC's promotional purposes. The names of minors will NOT be used with corresponding images. I understand there are inherent risks involved in any ministry or athletic event, and I hereby release PUMC, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my youth's involvement and related medical treatment.

Code of Conduct

My youth and I have read the rules of conduct and agree we will abide by the stated code of conduct. I understand my youth expect to behave in a way that properly represents themselves and PUMC. *If you desire to limit your youth's participation in any event, please submit your wishes in writing to PUMC prior to that event.*

Medical Release

I grant permission for the designated staff and sponsors of PUMC to seek medical treatment for my youth to receive medical treatment in the event of sickness or injury. I also grant permission for emergency medical treatment, including emergency surgery, required by a physician and/or hospital personnel. I also acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider.

Physician Name/City: ______________________________________ Phone: ________________

Insurance Company: ________________________________ Policy #: ____________________

Name:	Name:
DOB:	DOB:
History	History
☐ Asthma ☐ Sinusitis ☐ Bronchitis ☐ Kidney Trouble ☐ Heart Trouble ☐ Diabetes ☐ Dizziness ☐ Hay Fever	☐ Asthma ☐ Sinusitis ☐ Bronchitis ☐ Kidney Trouble ☐ Heart Trouble ☐ Diabetes ☐ Dizziness ☐ Hay Fever
Allergies:	Allergies:
Medication:	Medication:
Other instruction:	Other instruction:
OK to give acetaminophen / ibuprofen? ☐ Yes ☐ No	OK to give acetaminophen / ibuprofen? ☐ Yes ☐ No

____ ________________
Parent/Guardian Signature(s) Date