

STUDENT'S NAME: _____ **CURRENT SCHOOL:** _____ **DATE:** _____

I hereby give permission for my child named above to participate with the Student Ministry Programs at Broomfield United Methodist Church, Broomfield, CO for scheduled activities.

Transportation

I understand that the group will be traveling to and from events in one of the following:

- Private automobiles driven by parents, leaders or other responsible adults over the age of 21.
- Leased vehicles driven by parents, leaders or other responsible adults over the age of 21.
- Chartered coaches.
- Broomfield United Methodist Church vans.

SIGNATURE OF PARENT or LEGAL GUARDIAN

Use of Student Photos

Under the Family Right to Privacy Act, Broomfield United Methodist Church (BUMC) may photograph and video students during activities for use in BUMC publications and youth room display, including but not limited to newsletters, marketing materials, facebook page and website. Parents who do not wish to have photographs of their child(ren) used in BUMC publications must notify the Director of Student Ministries with a formal written request.

SIGNATURE OF PARENT or LEGAL GUARDIAN

Discipline

Should the discipline of my child become necessary, I understand that it is my responsibility to travel to the place of the event and retrieve my child. If I am planning to be away for this time, I will arrange for another responsible adult to be available. That person's name and phone number is listed as my Emergency Contact Person or Person(s) to Whom Child May Be Released. I will alert that person about the responsibility.

SIGNATURE OF PARENT or LEGAL GUARDIAN

Obtaining Emergency Medical Care

Intending to be legally bound, I hereby release Broomfield United Methodist Church, its staff and volunteers, from any claims that might occur as a result of my child's participation, from responsibility and liability for any injury or illness that my child may sustain or cause during participation in all youth ministry activities. In the case of an emergency, I hereby authorize an adult advisor, as agent for me, to consent to any reasonable medical and/or first aide treatment including, x-ray examination, medical, dental, or surgical diagnosis, treatment and/or hospital care advised and supervised by a physician, surgeon, or dentist or emergency and/or first aid provider within the geographic area we are located at the time of injury. I expect to be contacted as soon as reasonably practicable under the circumstances. I acknowledge Broomfield United Methodist Church, its staff and volunteers are not responsible for any medical bills incurred, and that I will be responsible for the bills incurred and/or requested for the benefit of my child.

SIGNATURE OF PARENT or LEGAL GUARDIAN: _____ DATE: _____

PRINT PARENT OR LEGAL GUARDIAN NAME: _____

AREA CODE and HOME PHONE NUMBER:(____)_____ CELL PHONE:(____)_____

PERIODIC REVIEW

SIGNATURE OF PARENT or LEGAL GUARDIAN: _____ DATE: _____

SIGNATURE OF PARENT or LEGAL GUARDIAN: _____ DATE: _____

SIGNATURE OF PARENT or LEGAL GUARDIAN: _____ DATE: _____

DATE OF LAST TETANUS SHOT:

**EMERGENCY CONTACT / PARENTAL CONSENT FORM
(PLEASE TYPE OR PRINT CLEARLY)**

CHILD'S NAME	BIRTHDATE	CURRENT SCHOOL
ADDRESS	HOME TELEPHONE NUMBER	
EMAIL	STUDENT'S CELL PHONE	
MOTHER'S NAME / LEGAL GUARDIAN	HOME TELEPHONE NUMBER IF DIFFERENT FROM CHILD	
ADRESS IF DIFFERENT FROM CHILD	MOTHER'S CELL PHONE	
MOTHER'S EMAIL	BUSINESS NAME & WORK PHONE	
FATHER'S NAME / LEGAL GUARDIAN	HOME TELEPHONE NUMBER IF DIFFERENT FROM CHILD	
ADRESS IF DIFFERENT FROM CHILD	FATHER'S CELL PHONE	
FATHER'S EMAIL	BUSINESS NAME & WORK PHONE	
EMERGENCY CONTACT PERSON(S) <small>OTHER THAN PARENT</small>	TELEPHONE NUMBER WHEN CHILD IS IN CARE	
1.		
2.		
3.		
NAME OF CHILD'S PHYSICIAN / MEDICAL CARE PROVIDER	TELEPHONE NUMBER	
ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY	MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)	
PARENTS INITIALS ARE REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING MEDICAL CARE	ADMINISTRATION OF MINOR FIRST AID - AID PROCEDURES	
TRANSPORTATION BY THE FACILITY	TRIPS	
WALKS, HIKES AND BICYCLES	SWIMMING / WADING / WATER SPORTS	

PERIODIC REVIEW

SIGNATURE OF PARENT or LEGAL GUARDIAN

DATE

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