ST. MARK'S UNITED METHODIST CHURCH
Where Mission is a Way of Life
4780 East 126th Street
Carmel, Indiana 46033-2408
(317) 846-4912
www.stmarkscarmel.org

General Release, Medical Authorization and Permission Statement

The undersigned parent(s) and/or guardian(s) of_____, in consideration of said child participating in any activity of the St. Mark's United Methodist Church, individually and as parent(s) and/or legal guardian(s) do hereby generally release and covenant to hold harmless the St. Mark's United Methodist Church and the duly authorized counselors, leaders, and approved assistants to the counselors and leaders of the activity from any action, cause or action, suits, damages, judgments, executions, claims and demands whatsoever, which the undersigned now have or may acquire by reason of any matter, cause or thing, and hold this agreement to terminate upon the above-listed child's ceasing participating as a member of the activity.

Medical Authorization

Furthermore, the undersigned parent(s) and/or legal guardian(s) authorize St. Mark's United Methodist Church and/or the United Methodist Youth Fellowship of the St. Mark's United Methodist Church by its duly authorized counselors, leaders, and approved assistants to the counselors and leaders of the fellowship to consent to reasonable and necessary medical care and to administer common, necessary medications including-but not limited to-acetaminophen ("Tylenol"), diphenhydramine ("Benadryl"), and ibuprofen ("Motrin"), as may be required for the above-listed child while participating in program and fellowships sponsored by the St. Mark's United Methodist Church and/or the United Methodist Youth Fellowship of the St. Mark's United Methodist Church.

The undersigned has caused this General Release, Permission Statement, and Medical Authorization to be executed on the following date:_____.

_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature

Please see reverse side. This form is not complete until the reverse side is complete.

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EMERGENCY AND MEDICAL INFORMATION

The following information is for the sole use of duly authorized counselors, leaders and approved assistants of St. Mark's United Methodist Church in case of an emergency, medical or otherwise.

Today's date_____

Name of youth_____

Birth date_____

Known allergies (food, insects, medicine, etc.)_____

Present Medications-strength and dose of prescribed and over the counter medications_____

Parent or Guardian (please print)_____

Phone-Home_____Cell_____Work_____

Alternate Contact (who can reach Parent or Guardian)_____

Phone_____

Name of Primary Care Physician_____

Office #_____

Hospital Preference_____

I, the undersigned, state this information to be correct and to the best of my knowledge.

Printed Name_____

Signature of Parent or Guardian_____Date_____

Please see reverse side. This form is not complete until the reverse side is complete.