

## **Dove of the Desert United Methodist Church**

My daughter/son \_\_\_\_\_, born on \_\_\_\_\_  
has my permission to participate in the youth activities sponsored by Dove of the  
Desert United Methodist Church.

### **MEDICAL RELEASE AND AUTHORIZATION**

The undersigned parents and/or guardians of the above, a minor, hereby release Dove of the Desert United Methodist Church (DOTD) and groups acting in cooperation with DOTD, and any members, counselors, pastors or otherwise, from any and all liability for any injuries or illness sustained or suffered by the said minor child while participating with the DOTD including travel from home to the sites of any events and return from there, including all activities in the course of the event or outing.

Further, this is to authorize the adult representatives of the DOTD and other groups acting in cooperation with the DOTD as counselors on said events, to retain such physicians, surgeons or other medical practitioners as may be necessary for the prompt treatment of our said minor child in the event of any injury or illness during the course of the above-described events.

Finally, in the event of an emergency, if it is impossible for adult representatives of the DOTD and other groups acting in cooperation with the DOTD to personally obtain the consent of the undersigned in advance, this is to authorize such physicians, surgeons, or other medical practitioners as may be retained by the said church representatives to perform such treatment as may be necessary for the benefit and the well-being of our said minor child.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Parent/Guardian)

Home Address: \_\_\_\_\_  
(State, City, and Zip Code)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Pager Number: \_\_\_\_\_

Notary: \_\_\_\_\_

THIS IS A BLANKET PERMISSION SLIP FOR ALL DOVE OF THE DESERT YOUTH ACTIVITIES.

Please fill out and bring to the Dove office along with your driver's license. Marti Betts is licensed to notarize your document.

**Health History** (Check - Give approximate dates)

Frequent Colds:	Athlete's Foot:	German Measles:
Heart Trouble:	Frequent Sore Throats:	Sleep Walking:
Kidney Trouble:	Sinusitis:	Tuberculosis:
Measles:	Abscessed Ears:	Allergies:
Convulsions/Epilepsy:	Bronchitis:	Appendicitis:
Poliomyelitis:	Fainting:	Asthma:
Rheumatic Fever:	Upset Stomach:	Chicken Pox:
Scarlet Fever:	Tonsillitis:	Pneumonia:
Bedwetting:	Diphtheria:	Diabetes:
Typhoid Fever:	Serious Ivy Poisoning:	Whooping Cough:
Mumps:	Constipation:	

Operations or Serious Injuries: \_\_\_\_\_

Mental/Emotional difficulties: \_\_\_\_\_

Allergic Reactions: Bee Sting:\_\_\_\_\_ Penicillin:\_\_\_\_\_ Foods:\_\_\_\_\_ Drugs:\_\_\_\_\_

Immunizations and date of last booster: Measles:\_\_\_\_\_ Tetanus:\_\_\_\_\_ Polio:\_\_\_\_\_

Rubella:\_\_\_\_\_

Activities Restrictions: \_\_\_\_\_

Please specify any other needs: \_\_\_\_\_

**Insurance Information**

Minor's Name: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_

Group Subscriber's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurer's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Emergency Contact Information (Other than a Parent)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Physician:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_