Date:

Wesley Memorial UMC Release Form

Full Name:________________________________ Birth date: _____/_____/_____

Insurance Company: __________________________ Policy Number: ___________________

Name of the Insured on Policy: ______________________________________

Please include a photocopy of the insurance card, front and back.

I acknowledge that I am either the person named above or the parent or legal guardian of the person named above (the "Participant") and do hereby authorize and grant permission for the Participant to participate in activities and events at or through Wesley Memorial United Methodist Church of Wilmington, North Carolina, Inc. ("WMUMC"). I further authorize and permit the Participant to be transported by agents or volunteers of WMUMC to, from, and/or during activities and/or events in which WMUMC may participate. I acknowledge that Participant shall obey and be subject to such rules and regulations as WMUMC shall establish for the safety of Participant and others.

I further authorize WMUMC, and/or any of its agents, employees or volunteers, to take the Participant to a physician, dentist or other health care provider for treatment of any injury, illness or sickness resulting from or occurring during any WMUMC activity or event. I acknowledge and agree that I am financially responsible for any and all such expenses that may be incurred by or on behalf of Participant in obtaining or receiving such medical services.

I do hereby irrevocably and unconditionally release, remise, acquit, discharge, and agree to hold harmless WMUMC and its directors, trustees, pastors, sponsors, agents, employees, servants, officers, representatives, volunteers, affiliates, divisions, subsidiaries, parents, predecessors, successors, heirs, assigns, administrators, executors and insurers from any and all liability, claims, actions, causes of action or demands of whatsoever nature for injury, damage, and/or loss to Participant or the property of Participant which have arisen or are now arising or hereafter may arise, and which are in any way related to Participant's participation, presence, and/or involvement to, from, or during any activity or event in which WMUMC may participate..

_______________________________________ Date: ____ / ____ / 20____
(Signature of Adult or Legal Guardian)

____
(Printed or Typed Name of Parent / Legal Guardian)

This authorization shall remain in full force and effect for one year from and after the date of execution of this document. In event of insurance or medical changes, please notify Wesley Memorial's Staff quickly.

Signed before me this day by ________________________________
(Name of principal).
Witness my hand and official seal, this the ______ day of ________________, 20____.
____
Official Signature of Notary

___________________, Notary Public
Notary's printed or typed name
My Commission Expires:__________ North Carolina, New Hanover County

Date:

WMUMC Health Information Form

Participant's Name ___________________________________ **Birthdate ___________**

Please check any condition listed below that affects the Participant:

Y	N		Y	N	
☐	☐	ADD/AHD	☐	☐	Heart problem
☐	☐	Asthma ________ (date of last attack)	☐	☐	Kidney/Urinary problem
☐	☐	Birth Defect	☐	☐	Migraines
☐	☐	Blood Disorder	☐	☐	Muscle/Bone problem
☐	☐	Cerebral Palsy	☐	☐	Missing organ/Transplant
☐	☐	Cystic Fibrosis	☐	☐	Seizures ________ (date of last seizure)
☐	☐	Diabetes	☐	☐	Sickle cell disease (not trait)
☐	☐	Hearing Problem	☐	☐	Wears glasses or contacts? ______
			☐	☐	Other Conditions (list below)

Please write a brief description of any "yes" answers or attach further information.

____

Are immunizations up-to-date? ☐ Yes ☐ No (Explain) ________________Date of last tetanus shot _________
Is there any reason that the Participant's activity should be restricted? ☐ Yes (explain) _______________ ☐ No

Allergic to: **Type of Reaction: (Circle)**

Food: _________________________ Breathing Problems Rash/Hives Swelling Vomiting

Medicine: _____________________ Breathing Problems Rash/Hives Swelling Vomiting

Insect Bites/Stings: ______________ Breathing Problems Rash/Hives Swelling Vomiting

Other: ________________________ Breathing Problems Rash/Hives Swelling Vomiting

If the Participant has an allergic reaction, are there specific instructions to follow in treatment?

List medicines (prescribed & over-the-counter) that the Participant takes at home and the reason:

List medicines or medical procedures that the Participant will require at events and the reason:

Physician's Name:_________________________________Physician's Phone: ________________________ ___________

Dentist's Name:_____________________________ Dentist's Phone: ________________________ _ __

Emergency Contact/relationship: ________________________________ Phone: ________________________ __

Adult Signature: ________________________________ **Date:** _____________________