

# Annual Medical Release and Permission Form

Skidaway Island Methodist Church  
912-598-8460  
54 Diamond Causeway, Savannah, GA 31411

Effective Dates: \_\_\_\_\_ to \_\_\_\_\_

Please print in ink and attach a copy of the student's medical insurance card (front and back).

Student's full name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

Year in school: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ C: \_\_\_\_\_ W: \_\_\_\_\_

Father's Name: \_\_\_\_\_ C: \_\_\_\_\_ W: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ C: \_\_\_\_\_ W: \_\_\_\_\_

Physician: \_\_\_\_\_ Office Number: \_\_\_\_\_

Dentist: \_\_\_\_\_ Office Number: \_\_\_\_\_

## Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability or condition to which your child is subject and of which the staff should be aware, and what if, any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary add another page with details:

1. For your child's safety and our knowledge, is your student a:  
 Good swimmer  Fair swimmer  Non-swimmer
2. Does your child have any allergies (i.e. pollens, medications, food, insect bites, etc.)?  
 Yes  No
3. If yes, please describe allergy and treatment:
  
4. Does your student suffer from, or has ever experienced, or is being treated currently for the following:  
 Asthma  Epilepsy/seizure disorder  Heart trouble  Diabetes  
 Frequently upset stomach  Motion sickness  Physical Handicap
5. Date of last tetanus shot \_\_\_\_\_
6. Does your student wear:  glasses  contact lenses  n/a
7. Please list and explain any major illnesses your student has experienced during the last year:

8. Additional comments:

9. Should this student's activities be restricted for any reason? If yes, please explain:

The above information is true and accurate to the best of my knowledge. I give my student permission to participate in youth and/or children's activities. I agree that my student will be informed of any indicated limitations and will abide by them.

Activities may include, but are not limited to: cookouts, boating, water skiing, swimming, basketball, games in the park, soccer, volleyball, softball, baseball, kickball, camping, skiing, snowboarding, hiking, concerts, Bible studies, miniature golf, hayrides, student ministry conferences, rock climbing, lock-ins, mission trips, service projects, small group trips, sleepovers, and more. IF you desire to limit your student's participation in any event, please submit your wishes in writing prior to the event.

This consent form gives permission to seek whatever medical attention is deemed necessary. All efforts will be made to contact parents or emergency contacts prior to medical attention. It needs to be clear, however, that the student's best interest and well-being will come first. Should a parent not be able to be reached, medical attention will begin. This permission releases Skidaway Island Methodist Church and its staff of any liability against personal losses of named child.

I/We, the undersigned, have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by Skidaway Island Methodist Church (SIMC). I/we understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release SIMC, 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/our student's involvement. In the event that s/he is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as is deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by SIMC. I/We agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately held responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/We also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the family ministries staff.

**Parent/Guardian's Name (printed):** \_\_\_\_\_

**Parent/Guardian's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_