



**Medical Release & Liability Release Form**  
(Release of all claims)

In consideration for being accepted by Sachse First United Methodist Church (hereafter referred to as SFUMC) or participation in **all children/youth trips and/or activities for the period beginning January 1, 2009 to December 31, 2009**: I as a parent and/or legal guardian of:

\_\_\_\_\_

hereby release, forever discharge and agree to hold harmless SFUMC, its directors, employees, and agents thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and/or the participant, that occurred by the undersigned and/or the participant, that occur while said person is participating in any trip or activity, including recreation and work activities. The undersigned further hereby agrees to hold harmless and indemnify SFUMC, its directors, employees, and agents for any liability sustained by said acts of said participant, including expenses incurred attendant thereto.

The undersigned further consents to the administration of first-aid and/or doctor's care, or any other form of medical treatment necessitated by illness or injury that may require the same. In the event of the necessity of such care or treatment as heretofore described, the undersigned agrees to hold harmless and indemnify SFUMC, its directors, employees, and agents from any acts of malfeasance, and/or failure to act on the part of those chosen to administer medical care on behalf of the participant.

\_\_\_\_\_  
Parent/Legal Guardian

State of Texas )

County of Dallas )

Before me a Notary Public in the state of Texas on this day personally appeared

\_\_\_\_\_, known to me as the person whose name is subscribed to the foregoing instrument and acknowledge to me that he/she executed said instrument for the purposes and consideration therein expressed.

Given under my seal this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary

## Medical Information

Participant's Name: \_\_\_\_\_

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

\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Recent Illnesses: \_\_\_\_\_

\_\_\_\_\_

Does your child have any:

Skin Diseases: \_\_\_\_\_ Lung Trouble: \_\_\_\_\_

Heart Trouble: \_\_\_\_\_ Allergies: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child require medication? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

### **In case of emergency notify:**

First Contact:

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

Second Contact:

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

### **Insurance Information:**

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

Policy / Group Number: \_\_\_\_\_

**Parent and/or Guardian Signature:** \_\_\_\_\_

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