SAINT STEPHEN

4600 S. Western Amarillo, TX 79109 Phone (806)355-7271 FAX (806)355-3891

YOUTH RELEASE AND CONSENT AGREEMENT

I do, hereby, for myself, my heirs, executors, and administrators, waive, release and forever discharge any and all rights and claims for damages which I may have or which may hereafter accrue to me against SAINT STEPHEN UNITED METHODIST CHURCH, Amarillo, Texas, their members, respective officers, agents, representatives, successors, and/or assigns, individually or collectively for any and all damages and liabilities which may be sustained and suffered by me in connection with my association with/or arising out of my traveling to, participation in, and returning from any activity sponsored by SAINT STEPHEN UNITED METHODIST CHURCH, Amarillo, Texas.

The patient and others whose signatures are attached below do hereby consent to any and all medical and surgical treatment, including anesthesia and operations, which may be deemed advisable by his or her physician and surgeons. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care be deemed advisable or necessary at the parent's or guardian's expense.

It is further noted that should said individual, traveling with the group, cause major damage to properties or display inappropriate behavior they will be placed on either a bus or plane and returned to Amarillo at the parent's expense.

In witness of our consent and agreement to the matters stated in the preceding sentences, we have subscribed our signatures below.

PARTICIPANTS NAME_____
(PLEASE PRINT) LAST FIRST MIDDLE

ADDRESS_____PHONE_____
STREET CITY STATE ZIP

PARTICIPANTS SIGNATURE _____

SIGNATURE OF PARENT(S) OR GUARDIAN_____

DATE_____

OVER

PARTICIPANTS DATE OF BIRTH:_____

MEDICATION BEING TAKEN? YES_____NO _____

SPECIFY_____

_____

My child has permission to take the following "over the counter" medications as needed: *(please check items that apply)*

_____ Acetaminophen (Tylenol) _____ Ibuprofen _____ Pepto-Bismol _____ Imodium

_____ Sinus Meds & Pain (Tylenol) _____ Benadryl _____ Dramamine _____ Midol (Girls Only)

_____ Cough & Sore Throat (Tylenol)

PARENTS NAMES_____

ADDRESS (IF DIFFERENT FROM PARTICIPANTS)_____

_____

HOME PHONE_____

FATHERS BUSINESS PHONE_____CELL #_____

MOTHERS BUSINESS PHONE_____CELL #_____

DOCTOR'S NAME_____PHONE_____

ANY OTHER HEALTH PROBLEMS_____

ALLERGIES:_____
(INCLUDING MEDICINES, SMOKE, ANIMALS)

PARTICIPANT'S LAST TETANUS SHOT_____

HEALTH INSURANCE COMPANY_____

POLICY NUMBER_____

MEMBER NUMBER/GROUP NUMBER_____

PRIMARY INSURED_____

INSURANCE ADDRESS_____

INSURANCE PHONE_____

ANOTHER RESPONSIBLE PERSON(S) TO CONTACT IN CASE OF AN EMERGENCY:

NAME:_____PHONE_____