

2010
PARENTS' RELEASE

The undersigned, parents of _____ a minor, release, discharge, and agree to hold harmless the Castleton United Methodist Church of Indianapolis, Indiana, and the trustees, staff and members thereof, from any personal injury or property damage sustained by their said minor while engaged or participating in activities sponsored by said Church, either on church premises or elsewhere, it being the intention of the undersigned to release any such claim of their said child, of whom they are the natural guardians, and individually as such child's parents for such injuries or property damage including expense of medical treatment, value of property lost or destroyed, and all other claims arising from the participation of their said child in activities sponsored by said church.

Further, should it be necessary for the participant to return home due to medical reasons, disciplinary action or otherwise, I (we) hereby assume all transportation costs.

It is our understanding that this document is valid one year from the date below.

WITNESS our hands this _____ day of _____, _____.

Parent/Guardian Signatures

State of _____

SS:

County of _____

Signed and sworn before me on this ____ day of _____, 20__.

Signature of Notary Public Printed Name

My County of Residence: _____

(Notary Seal)

My Commission Expires: _____

(Please complete both sides of this form.)

CONSENT FOR TREATMENT OF A MINOR CHILD

(Please Print)

I, (we) _____ and _____ of _____
(Parent Name) (Parent Name)

(City) (County) (State)

do hereby state that I am (we are) the parent(s) or legal guardian(s) of _____,
(Child's Name)
a minor, age _____, born _____, who resides with me (us) at _____

(Street Address)

I (we) authorize adults who are staff or members of the Castleton United Methodist Church in the city of Indianapolis, county of Marion, State of Indiana to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician licensed to practice medicine in the continental United States.

This release should be considered valid one year from date given below.

Dated this _____ day of _____, _____.

Allergies: _____

Date of last tetanus immunization: _____

(signature of parent/guardian) (signature of parent/guardian)

Phone #: _____
(Home) (Cell/Work)

Insurance Company: _____

Attach a copy of both sides of your health insurance card.

(Complete both sides of this form.)