

**FIRST UNITED METHODIST CHURCH – DOWNERS GROVE, ILLINOIS**  
**IGNITE STUDENT MINISTRY**  
**PERMISSION AND EMERGENCY INFORMATION**  
**2016-2017**

*(Separate form for each child in the same family required)*

**As parent or legal guardian, I hereby give permission for my child to participate on any Downers Grove First United Methodist Church / Sunday School / Ignite Youth / Onward Bound / Chapel Choir Events from August 26, 2016 through August 25, 2017. Before any big event, this form will be available for any updated information that you may need to provide pertinent to the event.**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(include City and Zip Code)

BIRTHDATE \_\_\_\_\_ HOME PHONE NUMBER \_\_\_\_\_

STUDENT'S CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

MOTHER'S NAME (First & Last) \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

FATHER'S NAME (First & Last) \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

**EMERGENCY CONTACTS:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number \_\_\_\_\_

**PROOF OF INSURANCE COVERAGE MAY BE NEEDED FOR SOME EVENTS:**

Health Insurance Company \_\_\_\_\_

Policy and/or Group Number \_\_\_\_\_

Name of policy holder \_\_\_\_\_

Billing Address \_\_\_\_\_

Telephone Number for claims \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone No. \_\_\_\_\_

***(PLEASE COMPLETE OTHER SIDE)***

Medical problems or Allergies Adult Leaders should be aware of: \_\_\_\_\_

\_\_\_\_\_  
(please include any pet or food allergies)

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

Prescription medication needed to be taken: (These must be given to trip nurse or group leader for Choir Tour or out-of-town trip to distribute.)

Name \_\_\_\_\_

Dosage and times \_\_\_\_\_

Side Effects (If any) \_\_\_\_\_

Any over-the-counter drugs or nutritional supplements currently being taken \_\_\_\_\_

Over-the-counter medication such as Advil, cough medicine and Imodium, for example, may be given to your child as needed, unless you specify otherwise.

- A. \_\_\_\_\_ Do not give any over-the-counter medicines.
- B. \_\_\_\_\_ OK to give over-the-counter medicines
- C. \_\_\_\_\_ OK to give over-the-counter medicines except for the following: \_\_\_\_\_

Does your son/daughter wear contact lenses? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are there any other problems, issues or concerns regarding your child that would be helpful for the Adult Leaders to know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check this box if you **DO NOT** want photo/video of your child(ren) used in any church publication (newsletter, web, etc.).

I am also aware that, in the event my child requires medical or dental treatment while engaged in Church or Youth Ministry activities, reasonable efforts will be made to contact me. However, if I cannot be reached, I hereby consent and give permission to the Adult Leaders acting on the behalf of the church, as agent for me to any X-ray examination; injections; anesthesia; medical, dental, or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are to be rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medication being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent or Guardian)