First United Methodist Church of Panama City
2014
Medical Release Form & Model Release Form

STATEMENT OF COMMITMENT

I, (Student Name)_____on this day of ____, ____, 2014 commit myself to: (a) fully participate in the First United Methodist Church of Panama City Children's event or trip; (b) faithfully attend and complete the required activities as directed by the Children's Director; (c) obey all rules and follow all guidelines established by First United Methodist Church of Panama City during the event or trip; (d) support the entire event with enthusiasm and a good attitude.

AUTHORIZATION FOR TREATMENT - RELEASE

I, the undersigned, do for myself (or for and on behalf of my child under 18 years of age) give my permission for an attending physician or hospital to administer medical care if deemed necessary by the Children's Director of First United Methodist Church of Panama City and the physician or hospital staff during the youth event.

I, the undersigned, do for myself, my heirs, executors, administrators, successors, and assignees (or for and on behalf of my child under 18 years of age and his/her heirs, executors, administration, successors, and assignees) understand that there is no secondary medical coverage provided by First United Methodist Church of Panama City. I, therefore, do hereby release from all claims and forever hold harmless the directors, officers, agents, and employees of First United Methodist Church of Panama City, from any and all claims and demands for personal injury, sickness, and death, as well as property damage and expenses, of any nature, incurred by myself (or my child under 18 years of age).

I also assume personal responsibility for all medical bills (for myself or my child under 18 years of age). Furthermore, should it be necessary for the participant to return home due to disciplinary action, for medical reasons, or otherwise, I hereby assume responsibility for all transportation costs.

PARTICIPANT MODEL RELEASE

By signing this document, the participant hereby gives First United Methodist Church of Panama City, their licensees, successors, legal representatives and assignees, the absolute and irrevocable right and permission to use the participant's name and to use, reproduce, edit, exhibit, project, display, copyright, publish photographic images and/or moving pictures and/or videotaped images of the participant with or without the participant's voice, or in which the participant may be included in whole or in part photographed, taped, videotaped, and/or recorded during the duration of the event, and therefore the circulate the same in all forms and media for art, advertising, trade, competition, of any description and/or lawful purpose and/or approve the finished product(s) or the editorial, promotional, or printed copy or soundtrack that may be used in connection therewith and any right that I may have to control the use to which said product(s), copy, and/or soundtrack may be applied. The participant discharges and agrees to save harmless First United Methodist Church of Panama City, their licensees, successors, legal representatives and assignees, from any liability by virtue of any blurring distortion, alteration, optical illusion or use in composite form whether intentional or otherwise, that may occur or be produced in the making, processing, duplication, projecting or displaying of said images, and from liability for violation of any personal or proprietary right that I may have in connection with said images and with the use thereof.

2014 PARTICIPANT MEDICAL INFORMATION

Name:_____ Date of birth: _____/_____/_____

Address:_____ Phone: _____

Generally, my health is (Please circle one) Excellent Good Fair Poor

If **Fair** or **Poor**, please explain your condition:_____

_____

List any medical conditions for which you are **currently** being treated:_____

_____

List any medications you are **currently** taking:_____

List any **medicines or substances** to which you are **allergic**:_____

_____

PLEASE PROVIDE THE FOLLOWING INFORMATION: **(With a copy of Insurance Card)**

Medical Insurance Carrier:_____

Policy or Group #_____ Personal ID #_____

Family Physician:_____ Phone:_____

Physician's address:_____

PLEASE SIGN AND COMPLETE BELOW

(FORM NOT VALID UNLESS ALL SIGNATURES ARE NOTARIZED)

Participant's Signature:_____ Date:_____/_____/_____

Parent or Guardian Signature:_____ Date:_____/_____/_____

Parent or Guardian Address:_____

1st Emergency Contact:_____ Relationship:_____

Home Phone: (850) -_____ Work Phone: (850) -_____ Cell Phone: (850)-_____

2nd Emergency Contact:_____ Relationship:_____

Home Phone: (850) -_____ Work Phone: (850) -_____ Cell Phone: (850)-_____

Other Emergency Contact:_____ Relationship:_____

Home Phone: (850) -_____ Work Phone: (850) -_____ Cell Phone: (850)-_____

FOR NOTARY USE ONLY **NOTARY STAMP**

Acknowledged before me this _____day of _____

Notary Signature _____

State of _____ My commission expires _____/_____/_____