

First United Methodist Church of Panama City Hold Harmless Form & Photo Release Form

STATEMENT OF COMMITMENT

I, (Participants Name) on this day of _____
commit myself to: (a) fully participate in the First United Methodist Church of Panama City event or trip; (b) faithfully attend and complete the required activities as directed by the leader(s); (c) obey all rules and follow all guidelines established by First United Methodist Church of Panama City during the event; (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 leader(s) of First United Methodist Church of Panama City and the physician or hospital staff during the 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.

Initial Here _____

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.

Initial Here _____

FUMC PARTICIPANT MEDICAL INFORMATION

Participant's Name: _____ Date of birth: _____

Address: _____ Phone: _____

Generally, my health is (Please select 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:

Medical Insurance Carrier: _____

Policy or Group # _____ Personal ID # _____

Family Physician: _____ Phone: _____

Physician's address: _____

PLEASE COMPLETE AND SIGN BELOW

Parent/Guardian Address: _____

1st Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

2nd Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Other Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian Print Name _____

Parent/Guardian Signature _____ Date: _____

FOR NOTARY USE ONLY	NOTARY STAMP
Acknowledged before me this _____ day of _____	
Notary Signature _____	
State of _____ County of _____	My commission expires ____ / ____ / ____