

**Health Information Form - MARINES  
APEX YOUTH MINISTRY: CRYSTAL SPRINGS UMC**

**Full Name** - \_\_\_\_\_

**Sex.** Male/Female                      **D.O.B** - \_\_\_\_\_

**Address** - \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Emergency Contacts**

**Contact 1: Name:** \_\_\_\_\_ **Number:** \_\_\_\_\_

**Contact 2: Name:** \_\_\_\_\_ **Number:** \_\_\_\_\_

**Family Doctors Name:** \_\_\_\_\_ **Number:** \_\_\_\_\_

**Are there any disabilities or special needs we need to know about?**

\_\_\_\_\_

\_\_\_\_\_

**Are you on any prescription medication? If so, list them and give us any special instructions (when to take, how much, do you want the chaperon to administer, etc.).**

\_\_\_\_\_

\_\_\_\_\_

**Do you have any on going medical conditions such as asthma or allergies that require medication?**

\_\_\_\_\_

\_\_\_\_\_

**Any special dietary needs?**

\_\_\_\_\_

\_\_\_\_\_

All information will be kept confidential, we cannot accept responsibility for any information not declared.

**I, the Parent/Guardian declare all this information is correct**

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Liability Release/Permission Form - MARINES  
APEX YOUTH MINISTRY: CRYSTAL SPRINGS UMC**

\_\_\_\_\_ (youth's name) has my permission to participate in MARINES with Crystal Springs UMC.

**PHOTO CONSENT**

I grant permission to CSUMC's representatives, to take and use: photographs and/or digital images of my youth for use in news releases and/or social promotions (publicity for future events, social media sites, website, etc). These materials might include printed or electronic publications, Web sites or other electronic communications. I acknowledge the church has the right to crop or treat the photograph(s) at its discretion. I also understand that once an image is posted on the church's website, the image can be downloaded by any computer user, anywhere in the world. Therefore, I agree to indemnify and hold harmless the church and it's representatives from any claims arising out of the use of my photograph(s). I authorize the use of these images without compensation. All negatives, prints, digital reproductions shall be the property of Crystal Springs UMC.

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Participant

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Parent must sign if participant is under 18 years of age

Date

**WAIVER OF LIABILITY**

I hereby release, waive, and discharge Crystal Springs UMC, its employees and representatives from any and all liability, claims, or demands arising from any loss, damage or injury that may be sustained by me, or to any property belonging to me while participating in any activity, or while in or upon the premises or in transportation to and from said premises.

To the best of my ability, I am in good physical condition to participate in this activity and I am fully aware of any risks and hazards connected with this activity. I voluntarily assume full risks of loss, property damage or personal injury that may be sustained by me, or any loss or damage to property owned by me, as a result of being engaged in this activity.

I further agree to hold harmless Crystal Springs UMC, its employees and representatives from any loss, liability, damages or cost that may incur due to my participation in this activity.

I understand that Crystal Springs UMC will not be responsible for any medical costs associated with any injury I may sustain.

In signing this Release, I acknowledge that I have read this Waiver of Liability and agree with its terms and conditions.

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Participant

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Parent must sign if participant is under 18 years of age

Date

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**CONSENT TO MEDICAL CARE AND TREATMENT OF A MINOR**

The undersigned authorize all medical, surgical, diagnostic and hospital procedures as may be performed or prescribed by a treating physician of hospital for above named son/daughter if we cannot be reached in case of an emergency.

Our consent includes, but is not limited to, administration of necessary anesthetics, medical treatment, tests, x-ray examinations, transfusions, injections, or drugs and the performing of whatever operations may be deemed necessary or advisable. Further, consent is granted to any such physician to exercise his/her discretion in authorizing the disposal of any severed tissue or member.

It is understood this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This authorization shall remain in effect until revoked in writing by the undersigned, with notice to the treating physician and hospital, or until the undersigned void their signatures hereon.

\_\_\_\_\_

Date

\_\_\_\_\_

Parent or Legal Guardian Signature