

STUDENT MINISTRY MEDICAL FORM 2020-2021 SCHOOL YEAR

ST. JOHN'S UNITED METHODIST CHURCH 6611 Proctor Rd. Sarasota, FL. 34241 941.925.2661

STATEMENT OF POLICY: Your child will be covered by St. John's comprehensive insurance policy during church organized activities and St. John's will be liable for your child while under the supervision of the staff and adult volunteers. All children will be transported to and from the activities in a vehicle driven by an adult 21 years of age or older. If your child needs to leave the activity early in his or her own vehicle or with someone other than his or her parent or custodian, the written consent of the parent or custodian will be required. At the scheduled conclusion of the activity, the parent or custodian is required to provide transportation from St. John's Church to home. Participants and their parents or custodians must consent to and acknowledge that during the event, the child will be under the supervision of the staff or adult volunteers and that the child will be expected to follow the instructions and directions of the staff and adult volunteers. *Inappropriate behavior by a child will result in the parent or custodian being contacted to pick the child up during the activity.*

My son/daughter's picture can be used for website, social media, and promotional materials _____
(no names will accompany images) (Parent Initials)

Consent to Participate and Medical Care Authorization

State of Florida, County of Sarasota

I, _____, parent/guardian of _____,
date of birth: _____, hereby authorize my child _____ to participate in
the student activities of St. John's United Methodist Church and I further authorize the staff and adult volunteers of St
John's United Methodist Church to obtain any and all medical and/or emergency care which, in their opinion, is needed
by my child during these activities. I agree and understand the Statement of Policy set forth above and understand
that inappropriate behavior by my child will result in my being contacted to pick up my child during the activity.

PARENT/GUARDIAN CONTACT IN CASE OF EMERGENCY OR BEHAVIOR PROBLEM:

Day/Business Phone: _____ Eve/Home Phone: _____

IF PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE NOTIFY:

Name and Relationship: _____

Phone: _____ Alternative Phone: _____

Parent Signature

Printed Name

Date

ACKNOWLEDGEMENT OF STUDENT

I understand and agree to be bound by the above Statement of Policy.

Student Signature

Date

TO BE COMPLETED BY NOTARY PUBLIC:

The foregoing Consent to Participate and Medical Care Authorization was acknowledged before me this ____ day of,
20____, by _____ who is personally known to me, or has produced (type of
identification) _____ as identification.

Notary Public (signature): _____

Name of Notary (printed): _____

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HEALTH RECORD

FULL STUDENT NAME _____

Date of birth _____ Gender _____

School & Grade _____

Has there been a recent exposure to contagious disease including Covid-19? _____

If yes, what and when _____

Please list allergies, reactions or health concerns:

Any history of: Congenital deformity or major disability? _____

Describe: _____

Chronic infection of nose, throat, ears or sinus? _____

Asthma? _____ Tendency to faint? _____ Seizures _____ Sleep Walking? _____

Convulsive Seizures/Epilepsy? _____ Sleep Walking? _____

Bed wetting? _____ Athlete's foot? _____

Has girl menstruated? Yes ___ no ___

Any recent operations, serious injuries or illness? _____ Describe _____

Other: _____

List present medications: _____

What restrictions, if any, should be observed?

Tetanus inoculation date: _____

(Student **must** have had series of DTaP, DT or Tetanus booster in past five years.)

Please attach copy (front/back) of health insurance card. Insurance Card attached? _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date _____
