**Marion Methodist**
**Emergency Contact and Medical Release**
**5050 REC Dr, Marion IA 52302 • (319)377-4856**

Last Name:

## Student 1
Full Name:
Date of Birth:
Gender: ☒ Male ☒ Female
High School Graduation Year:
Medical Needs (list allergies, medications, and other pertinent issues):

## Student 2
Full Name:
Date of Birth:
Gender: ☐ Male ☐ Female
High School Graduation Year:
Medical Needs (list allergies, medications, and other pertinent issues):

## Student 3
Full Name:
Date of Birth:
Gender: ☐ Male ☐ Female
High School Graduation Year:
Medical Needs (list allergies, medications, and other pertinent issues):

## Contacts & Emergency Information
Mother/Primary: Contact Phone #:
Father/Primary: Contact Phone #:
Emergency Contact: Contact Phone #:
Email Address:
Home Address:
Medical Insurance Company:
Policy Number:

## Release Information
By submitting this form, you allow **Marion Methodist** to seek whatever medical treatment is deemed necessary and release the church and its staff of any liability. In the case of a medical emergency, you take responsibility for medical care and the cost of any care provided to the students named above. You give consent for the students named above to be involved in the youth ministry of **Marion Methodist** and understand that photos and videos of your child may be used in materials for the church and youth ministry. Please type your name below in order to digitally agree to the information contained in this form and release **Marion Methodist** of liability. This form is current for one year from the date signed below.

Parent/Guardian Digital Signature:
Date: