

**First United Methodist Church, Gainesville, FL**  
**Youth Activities Waiver and Medical Release Form**

**A note to parents:**

The leaders of the youth ministry at FUMC are given the sacred task of guiding the spiritual formation of youth participants in our programs. We do our best to provide a healthy environment in which our youth may grow in relationship to God and each other. We approach this task seriously, enthusiastically, and humbly. We welcome your input at any time and look forward to helping your youth grow to become a faithful disciple of Jesus Christ.

Sincerely,

Youth Director

**Youth Behavior Covenant of Conduct for all FUMC Functions:**

*I understand that all youth are expected to exemplify Christian behavior in all areas of conduct. This includes appropriate language, respectful and positive relationships with peers (including no public display of affection), and cooperation with all adult leaders.*

\_\_\_\_\_  
Signature of Legal Guardian – REQUIRED

\_\_\_\_\_  
Signature of Youth – REQUIRED

I give my permission for \_\_\_\_\_ to attend all FUMC – Gainesville youth events on or off site. I will not hold FUMC – Gainesville, church employees, or adult leaders liable for harm to the above-named youth (including injury, illness, or mishap) that occurs during scheduled activities or for any harm my youth causes during such activities. I understand that the adult leaders of FUMC – Gainesville youth events will make all reasonable efforts to protect my youth’s safety and well-being. In the event of any emergency, accident, or illness I want the adult leaders to notify me as soon as reasonably possible.

**IN THE EVENT OF A MEDICAL EMERGENCY, I APPOINT FUMC – GAINESVILLE OR ITS REPRESENTATIVE TO AUTHORIZE MEDICAL CARE FOR MY YOUTH.**

Full Name of Youth \_\_\_\_\_

Birth Date \_\_\_\_\_ Current Grade \_\_\_\_\_

Name and Relationship of Legal Guardian \_\_\_\_\_

Emergency Contacts’ Phone Numbers \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Doctor’s Name \_\_\_\_\_ Office/Hospital Number \_\_\_\_\_

Special Healthcare Needs/Medications \_\_\_\_\_

Signature of Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_