

FIRST UNITED METHODIST CHURCH OF ANNISTON,  
ALABAMA, INC.

Programs for Children and Youth Participation Permission and  
Liability Release

I hereby grant my child, \_\_\_\_\_, permission to attend and participate in all church activities,  
(Full Name of child)

field trips and ventures offered by and/or through FIRST UNITED METHODIST CHURCH ANNISTON, ALABAMA, INC.,( hereinafter referred to as "Anniston First") beginning on January 1, 2012 until this Release is revoked in writing and said writing is delivered to Anniston First. The attendance of my child at any church activity constitutes my acceptance to the terms of this Release.

I accept full responsibility for my child's actions and I hereby indemnify and hold harmless Anniston First, its agents, employees and assignees from any and all damages caused by my child, accidentally or willfully, to property owned by Anniston First and property of those acting as employees, agents or assigns of Anniston First, including, without limitation, volunteers and church staff.

I father accept full responsibility for my child's safety and I hereby harmless, Anniston First, its agents employees and assigns, including, without limitation, volunteers and church staff, for any and all damagers arising out of or resulting from my child's participation in any activity.

In the event of injury or illness of my child while engaged in an Anniston First activity, Anniston First, it agents, employees and assigns have my permission to seek such medical care as needed or and emergency basis and I hereby indemnify Anniston First, it agents employees and assigns for all expense incurred for the benefit of my child. Dated this the \_\_\_\_ day of \_\_\_\_\_ 2012.

\_\_\_\_\_  
(Signature of Mother)

\_\_\_\_\_  
(Signature of Child)

\_\_\_\_\_  
(Signature of Father)

**TELEPHONE NUMBERS**

Home \_\_\_\_\_

Local relative/friend \_\_\_\_\_

Mother's work \_\_\_\_\_

Mother's cell \_\_\_\_\_

Father's work \_\_\_\_\_

Father's cell \_\_\_\_\_

Emergency Number \_\_\_\_\_

Child's Physician \_\_\_\_\_

Name of Health Insurance Company: \_\_\_\_\_

Health Insurance company Group Number & policy Number: \_\_\_\_\_

Full name of insured: \_\_\_\_\_

Social Security Number of insured: \_\_\_\_\_

**Additional pertinent information may be noted on the back of this form.**