ANDREWS CHAPEL
United Methodist Church
"Opening New Doors of Opportunities for Ministry"

122 Watterson Street
Jonesboro, GA 30236
(770) 471-7200

## Safe Sanctuary Policy

# Adult Off-site Trip Packet

***The ACUMC is a fellowship of believers called to witness to our faith and to make disciples of Jesus Christ….***

## Off-site Trip Procedures

The forms and documents in this packet must be completed for all off-site trips sponsored by Andrews Chapel United Methodist Church. The sponsor or organizer of the trip must obtain this Off-Site Packet online or from the church secretary and ensure that the appropriate **forms are completed and a copy given to the church secretary prior to leaving on the trip.**

**The sponsor or organizer should retain the original copies and bring them with him or her on the trip to use if needed.**

**Please be reminded that information on these forms is confidential and must be carefully and appropriately managed.**

| | | |
|---|---|---|
| Departure Date/Time | Return Date/Time | |
| Name of Organization Sponsoring Trip | | |
| Destination | | |
| Mode of Transportation (church bus, personal vehicle, rented vehicle, airplane, etc.) | | |
| If personal vehicle/rental is used, does the driver have a valid license and a valid insurance policy? | ☐ Yes | ☐ No |
| Name of driver: | | |
| If personal vehicle/rental is used, are there at least two riders in addition to the driver in the vehicle? | ☐ Yes | ☐ No |
| ***Roster of Participants*** completed and copy left with church secretary? | ☐ Yes | ☐ No |
| ~~***Children & Youth Permission and Medical Consent Form*** obtained for all children & youth participating?~~ | ~~☐ Yes~~ | ~~☐ No~~ |
| ***Adult Medical Consent Form*** completed, signed and dated by each participating adult? | ☐ Yes | ☐ No |

## Roster of Participants with Emergency Contacts

**Date:**

**Name of ministry / work area sponsoring trip:**

| NAME | EMERGENCY CONTACT # |
|---|---|
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**NOTE: Each person on the trip should list an emergency contact telephone number.**

# Adult Medical Consent Form

| | | |
|---|---|---|
| **Name of Activity:** | | |
| Your Full Name (Last, First, Middle): | | |
| Sex: | Birthday: | Age: |
| Home Address: | | |
| City: | State: | Zip Code: |
| Day Phone: | Evening Phone: | |
| Email Address: | | |
| | | |
| **Emergency Contact:** | | |
| 1. Name: | Relationship to You: | |
| Street Address: | | |
| City: | State: | Zip Code: |
| Day Phone: | Evening Phone: | |
| Email Address: | | |
| 2. Name: | Relationship to You: | |
| Street Address: | | |
| City: | State: | Zip Code: |
| Day Phone: | Evening Phone: | |
| Email Address: | | |
| | | |
| Do you have any of the following allergies? | | |
| Penicillin | | **[ ] YES [ ] NO** |
| Other Drugs (please list): | | **[ ] YES [ ] NO** |
| Insect Stings | | **[ ] YES [ ] NO** |
| Ivy Poisoning, etc. | | **[ ] YES [ ] NO** |
| Hay Fever | | **[ ] YES [ ] NO** |
| Others (please list): | | **[ ] YES [ ] NO** |

| | |
|---|---|
| Do you have any medical or health problems; any chronic or recurring illness; and / or any restrictions which would have an effect on your participation in this activity? If yes, describe the problem, illness or restriction: | **[ ] YES [ ] NO** |
| What medications are you taking? List the names and dosages: | |
| Describe any dietary restrictions that you observe: | |
| Other health conditions / pertinent information: | |

**Who is your Primary Physician and / or any other physician who should be consulted in the event of emergency or medical problems involving you:**

| | |
|---|---|
| Primary Doctor's Name: | Medical Specialty: |
| Address: | Phone #: |
| Other Doctor's Name (if applicable) : | Medical Specialty: |
| Address: | Phone #: |

| **Do you have medical or hospitalization insurance? If so, please indicate:** | **[ ] YES [ ] NO** |
|---|---|
| Name of Insurance Company: | |
| Address: | Phone #: |
| Name of Policy Holder: | Policy Number: |
| ***A copy of the medical or hospitalization insurance card must be attached to this form. The form and copy of the insurance card will be destroyed <u>one year</u> after the conclusion of the activity.*** | |

I understand that **__Andrews Chapel UMC____** does not carry medical and hospitalization insurance coverage. I understand that I am responsible for having personal medical and hospitalization insurance for my family.

I further understand that, in the event that I require medical or dental treatment while engaged in the activity and I am unable to act on my own behalf, I hereby consent and give permission to the ministry's sponsor or any adult acting on behalf of the ministry with respect to the activity, to act as agent for me, to consent to any X-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my medical allergies, medications being taken, medical problems and other pertinent information. I am able to participate in all prescribed activities except as noted by me.

Signature _____ Date _____

Witness _____ Date _____

## Accident Report

| | | | |
|---|---|---|---|
| Date Form Completed: | | | |
| Name of person reporting the accident: | | | |
| Home Phone: | | Work/Cell Phone: | |
| Location of the accident: | | Date of the accident: | Time of accident: |
| Description of the accident: | | | |
| Names & Phone # of other witnesses to the accident: | | | |
| Name of injured: | | Age of injured: | |
| Parent or Guardian of injured: | | Date and Time when notified: | |
| Home Phone: | | Work/Cell Phone: | |
| Street Address: | | City: | |
| | | | |
| ACUMC Staff notified | Name(s): | Date(s): | Time: |
| | | | |
| Resolution/Follow-up: | | | |
| | | | |
| Signature of person completing this Accident Report: | | | |

## Abuse or Harassment Incident Report

| | | | |
|---|---|---|---|
| Date Form Completed: | | | |
| Name of person reporting the incident: | | | |
| Home Phone: | | Work/Cell Phone: | |
| Names & Phone # of other witnesses to the incident: | | | |
| Victim's Name: | | Victim's age: | |
| Name of Victim's Parents or Guardians: | | | |
| Home Phone: | | Work/Cell Phone: | |
| Street Address: | | City: | |
| | | | |
| When incident was observed | Date: | Time: | Location: |
| Description of the incident (include words spoken and behavior or actions observed): Continue on reverse side if needed. | | | |

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|---|---|---|---|
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| Physical Evidence: | | | |
| | | | |
| ACUMC Staff notified | Name(s): | Date(s): | Time: |
| | | | |
| Signature of person completing this Incident Report: | | | |