



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

## Safe Sanctuary Policy

# Children / Youth 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of driver:		
If personal vehicle/rental is used, are there at least two riders in addition to the driver in the vehicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Roster of Participants</b> completed and copy left with church secretary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Children &amp; Youth Permission and Medical Consent Form</b> obtained for all children & youth participating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Adult Medical Consent Form</b> completed, signed and dated by each participating adult?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Roster of Participants with Emergency Contacts

**Date:**

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

NAME	EMERGENCY CONTACT #

**NOTE: Each person on the trip should list an emergency contact telephone number.**

## Children & Youth Permission and Medical Consent Form

As parent or legal guardian, I hereby give permission for my child to participate in the following activity (the "Activity") organized by Andrews Chapel United Methodist Church.

Name of Activity:		
Child's Full Name (Last, First, Middle):		
Sex:	Birthday:	Age:
Home Address:		
City:	State:	Zip Code:
Day Phone:		Evening Phone:
Email Address:		
Emergency Contact:		
1. Name:		
Street Address:		
City:	State:	Zip Code:
Day Phone:		Evening Phone:
Email Address:		
2. Name:		
Street Address:		
City:	State:	Zip Code:
Day Phone:		Evening Phone:
Email Address:		
<b>Does this child have any of the following allergies?</b>		
Penicillin	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other Drugs	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Insect Stings	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ivy Poisoning, etc.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hay Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Others (please list):		[ ] YES	[ ] NO
Does this child have any medical or health problems, and has this child had any chronic or recurring illness or illnesses, which would have an effect on the child's participation in this activity? If yes, describe the problems or illnesses:		[ ] YES	[ ] NO
<b>This child's family physician and any other physician who should be consulted in the event of emergency or medical problems involving this child:</b>			
Doctor's Name:		Medical Specialty:	
Address:		Phone #:	
<b>This child's dentist (and orthodontist if applicable):</b>			
Dentist's Name:			
Address:		Phone #:	
<b>Is there medical or hospitalization insurance which provides benefits for this child?</b> [ ] YES      [ ] NO <b>If so, please indicate:</b> Name of Insurance Company:			
Address:		Phone #:	
Name of Policy Holder:		Policy Number:	
<b><i>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></b>			
Date of this child's last tetanus shot:			
Are there any activities, such as strenuous activities, to be restricted for this child? If so, describe:			

**Is this child on any medications? [ ] YES [ ] NO**

**If so, please state the medication:**

**If so, will this child be bringing to the activity the medications that he/she should be taking?  
[ ] YES [ ] NO**

**Describe any dietary restrictions that this child is required to observe:**

**Other comments or suggestions from the parent or guardian concerning this child:**

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 my child requires medical or dental treatment while engaged in the activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's sponsor or any adult counselor acting on behalf of the ministry with respect to the activity, 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 child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

**Signature \_\_\_\_\_ Date \_\_\_\_\_**  
**(Parent or Guardian)**

**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.			



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