Parental Medical and Liability Waiver release statement

As the parent or legal guardian of the student named below, I hereby give my full consent and approval for my child to participate in the _____

_____

_____

_____

I understand that in the event medical intervention is needed, every attempt will be made to immediately contact the persons listed on this form. In the event I cannot be reached in an emergency during the aforementioned dates, I hereby give my permission to all attending health care professionals (including, but not limited to nurses, LPNs, PAs, paramedics, doctors, or dentists) selected by the Youth Pastor or activity leader to hospitalize, secure medical treatment, and/or order an injection, anesthesia, or surgery for my teen as deemed necessary.

I understand that my insurance coverage will be used as primary and sole coverage for my teen in the event medical intervention is needed.

I understand all reasonable safety precautions will be taken by_____

_____ **and its agents during all events and activities as described, but not limited to the events listed. I recognize the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold** _____ **its directors, pastors, leaders, employees, or volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.**

I further authorize the church staff to send my child home at my expense due to his/her willful misconduct and inappropriate actions contrary to set guidelines or rules.

(Please fill out form in ink.)

FULL NAME OF COVERED STUDENT: _____

Parent/Guardian #1 Signature: _____

Printed Name: _____

Date Signed: _____ Telephone: _____

Parent/Guardian #2 Signature: _____

Printed Name: _____

Date Signed: _____ Telephone: _____

_____

SIGNATURE OF STUDENT (IF OVER 18 YEARS OF AGE)

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(PLEASE PRINT ALL INFORMATION WITH INK)

Participant's Name: _____

Date of Birth: _____ Sex: _____ Age: _____ Grade: _____

Street: _____ City: _____

State: _____ Zip: _____ Home Telephone: ( ) _____

Height: _____ Weight: _____ Today's Date: _____

PRIMARY EMERGENCY CONTACT

Name: _____ Relationship: _____

Address (if different than above): _____

City: _____ State: _____ Zip: _____

Home Telephone: ( ) _____ Business Telephone: ( ) _____

Place of Business: _____

ALTERNATE EMERGENCY CONTACT

Name: _____ Relationship: _____

Address (if different than above): _____

City: _____ State: _____ Zip: _____

Home Telephone: ( ) _____ Business Telephone: ( ) _____

Place of Business: _____

Do you have hospital insurance? (Circle correct response) YES NO

_____ _____
Print Insurance Company's Name Policy Number

_____ _____
Doctor's Name Doctor's Office Number

List pre-existing or current medical conditions: _____

_____

List any allergies: _____

Medication allergies: _____

If currently taking any medications, names and dosages: _____

_____

Contact Lenses? YES NO Date of last Tetanus Shot: _____ (I 0 yr. expiration)

If medical attention is required for injuries received or illnesses contracted prior to trip/activity, please send necessary information/materials to ensure proper medical care during the trip.)

Revised. June 2003