

MEDICAL RELEASE FORM

RICHARDSON EAST CHURCH OF CHRIST YOUTH GROUP

EFFECTIVE DATES:
1/1/11 - 12/31/11

GENERAL INFORMATION:

NAME: _____ AGE: _____ BIRTHDAY: _____
 LAST FIRST MIDDLE

YEAR IN SCHOOL: _____ MALE FEMALE EMAIL: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ TEEN'S CELL: _____

EMERGENCY CONTACT INFORMATION:

MOTHER'S NAME: _____ FATHER'S NAME: _____

PHONE # HOME: _____ PHONE # HOME: _____

PHONE # CELL: _____ PHONE # CELL: _____

PHONE # WORK: _____ PHONE #WORK _____

EMERGENCY CONTACT (OTHER THAN PARENT):

NAME: _____ PHONE: _____

MEDICAL INFORMATION:

MEDICAL INSURANCE COMPANY: _____

POLICY NUMBER: _____

PHYSICIAN: _____ OFFICE PHONE: _____

DENTIST: _____ OFFICE PHONE: _____

MEDICAL HISTORY:

IF NECESSARY, DESCRIBE IN DETAIL THE NATURE AND SEVERITY OF ANY PHYSICAL AND/OR PSYCHOLOGICAL AILMENT, ILLNESS, PROPENSITY, WEAKNESS, LIMITATION, HANDICAP, DISABILITY, OR CONDITION TO WHICH YOUR CHILD IS SUBJECT AND OF WHICH THE SPONSORS SHOULD BE AWARE, AND WHAT, IF ANY, ACTION OF PROTECTION IS REQUIRED ON ACCOUNT THEREOF. SUBMIT THIS NOTIFICATION IN WRITING AND ATTACH IT TO THIS FORM. INCLUDE NAMES OF MEDICATIONS AND DOSAGES THAT MUST BE TAKEN.

CHECK THE FOLLOWING AREAS OF CONCERN FOR THIS STUDENT:

(IF NECESSARY, ADD ANOTHER PAGE WITH DETAILS)

1. FOR YOUR STUDENT'S SAFETY AND OUR KNOWLEDGE, IS THIS STUDENT A...
 GOOD SWIMMER FAIR SWIMMER NON-SWIMMER

2. DOES YOUR STUDENT HAVE ALLERGIES TO...
 POLLENS MEDICATIONS FOOD INSECT BITES

3. DOES YOUR CHILD SUFFER FROM, OR HAS EVER EXPERIENCED, OR IS BEING TREATED CURRENTLY FOR ANY OF THESE...
 ASTHMA EPILEPSY/SEIZURE DISORDER HEART TROUBLE PHYSICAL HANDICAP
 DIABETES FREQUENTLY UPSET STOMACH OTHER

4. DATE OF LAST TETANUS SHOT: _____

5. DOES YOUR CHILD WEAR: GLASSES CONTACT LENSES

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FOR YOUR INFORMATION, WE EXPECT EACH STUDENT TO CONFIRM TO THESE RULES OF CONDUCT:

- * NO POSSESSION OR USE OF ALCOHOL, DRUGS, OR TOBACCO
- * NO FIGHTING, WEAPONS, FIREWORKS, LIGHTERS, OR EXPLOSIVES
- * NO OFFENSIVE OR IMMODEST CLOTHING
- * NO BOYS IN GIRL'S SLEEPING QUARTERS AND NO GIRLS IN BOY'S SLEEPING QUARTERS
- * PARTICIPATION WITH THE GROUP IS EXPECTED
- * RESPECT PEOPLE AND THEIR PROPERTY
- * RESPECT ONE ANOTHER AND ADULT SPONSORS
- * RESPECT AND COMPLY WITH EVENT RULES AND SCHEDULES

STUDENTS WHO FAIL TO COMPLY WITH THESE EXPECTATIONS MAY BE SENT HOME AT THEIR PARENT'S EXPENSE!!!

I, THE STUDENT, HAVE READ THE RULES ABOVE AND AGREE TO ABIDE BY THE STATED CODE OF CONDUCT.

NAME: _____ DATE: _____

ACTIVITIES MAY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING, COOKOUTS, BOATING, WATER SKIING, SWIMMING, CLIFF DIVING, BASKETBALL, ROLLER SKATING, ROLLERBLADING, SNOW SKIING, MOUNTAIN HIKING, GAMES IN THE PARK, SOCCER, BROOM-BALL, ICE SKATING, VOLLEYBALL, SOFTBALL, BASEBALL, CAMPING, SNOWBOARDING, BIKING, CONCERTS, BIBLE STUDIES, GOLFING, MINIATURE GOLF, HAYRIDES, ROLLERCOASTERS, AND AMUSEMENT PARKS. (NOTE: IF YOU DESIRE TO LIMIT YOUR CHILD'S PARTICIPATION IN ANY EVENT, PLEASE SUBMIT YOUR WISHES IN WRITING TO THE CHURCH YOUTH MINISTER PRIOR TO THAT EVENT.)

_____ HAS MY PERMISSION TO ATTEND ALL YOUTH ACTIVITIES
NAME OF STUDENT

SPONSORED BY RICHARDSON EAST CHURCH OF CHRIST YOUTH MINISTRY FROM 1/1/11 TO 12/31/11.

THIS CONSENT FORM GIVES PERMISSION TO SEEK WHATEVER MEDICAL ATTENTION IS DEEMED NECESSARY, AND RELEASES THE CHURCH AND ITS STAFF OF ANY LIABILITY AGAINST PERSONAL LOSSES OF NAMED CHILD.

I/WE THE UNDERSIGNED HAVE LEGAL CUSTODY OF THE STUDENT NAME ABOVE, A MINOR, AND HAVE GIVEN OUR CONSENT FOR HIM/HER TO ATTEND EVENTS BEING ORGANIZED BY THE CHURCH OF CHRIST. I/WE UNDERSTAND THAT THERE ARE INHERENT RISKS INVOLVED IN ANY MINISTRY OR ATHLETIC EVENT, AND I/WE HEREBY RELEASE THE CHURCH, ITS MINISTERS, EMPLOYEES, AGENTS, AND VOLUNTEER WORKERS FROM ANY AND ALL LIABILITY FOR ANY INJURY, LOSS, OR DAMAGE TO PERSON OR PROPERTY THAT MAY OCCUR DURING THE COURSE OF MY/OUR CHILD'S INVOLVEMENT. IN THE EVENT THAT HE/SHE IS INJURED AND REQUIRES THE ATTENTION OF A DOCTOR, I/WE CONSENT TO ANY REASONABLE MEICAL TREATMENT AS DEEMED NECESSARY BY A LICENSED PHYSICIAN. IN THE EVENT TREATMENT IS REQUIRED FROM A PHYSICIAN AND/OR HOSPITAL PERSONNEL DESIGNATED BY THE CHURCH REPRESENTATIVES, I/WE AGREE TO HOLD SUCH PERSON FREE AND HARMLESS OF ANY CLAIMS, DEMANDS, OR SUITS FOR DAMAGES ARISING FROM THE GIVING OF SUCH CONSENT. I/WE ALSO ACKNOWLEDGE THAT WE WILL ULTIMATELY RESPONSIBLE FOR THE COST OF ANY MEDICAL CARE SHOULD THE COST OF THAT MEDICAL CARE BE REIMBURSED BY THE HEALTH INSURANCE PROVIDER. FURTHER I/WE AFFIRM THAT THE HEALTH INSURANCE INFORMATION PROVIDED ABOVE IS ACCURATE AT THIS DATE AND WILL, TO THE BEST OF MY/OUR KNOWLEDGE, STILL BE IN FORCE FOR THE STUDENT NAMED ABOVE. I/WE ALSO AGREE TO BRING MY/OUR CHILD HOME AT MY/OUR OWN EXPENSE SHOULD THEY BECOME ILL OR IF DEEMED NECESSARY BY THE YOUTH MINISTRIES STAFF MEMBER.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____