

CHRISTIAN FELLOWSHIP CHURCH YOUTH MINISTRIES GENERAL RELEASE AND WAIVER FOR ANY/ALL ACTIVITIES

In consideration of the child's participation in any and all activities of the youth ministry, I, individually and on behalf of any other parent or guardian of the Child release Christian Fellowship Church and their employees, officers, staff, and volunteers from any and all claims which may result from participation of the child in any youth ministry activities and related activities or which may result from any other matter or occurrence whatsoever, including negligence or carelessness.

STUDENT'S NAME Last _____ First _____ Middle _____

MEDICAL HISTORY

Date of last Tetanus Shot _____ DOB _____

Please check if applicable:

Convulsions/Epilepsy Heart Disease Bleeding/Clotting Disorder

Diabetes _____ Other (list) _____

ALLERGIES: Insect Stings Asthma - Last Peak Flow _____ Medications (list below with medications not to be taken)

Hay Fever Food and Other (list) _____

MEDICATIONS THAT SHOULD NOT BE TAKEN _____

MEDICATIONS TAKEN REGULARLY

Medicine	Dosage	Frequency	Taken For
1			
2			
3			

MEDICAL INSURANCE INFORMATION

Participant's Name _____ Medical Insurance Carrier _____

Policy # _____ Group # _____ Subscriber _____

Does the insurance plan require services be provided by or authorized by a primary care physician? _____

Primary Care Physician Name _____ Phone # _____

Dentist or Orthodontist Name _____ Phone # _____

PARENT OR GUARDIAN AUTHORIZATIONS

I hereby give my permission for photographs in which students may appear to be used by Christian Fellowship Church in their promotional activities.

To the best of my knowledge, the information provided herein is correct and complete. I hereby give my permission for this form to be photocopied. **In the event I cannot be reached in an emergency, I hereby give permission for a physician selected by the group leaders to order x-rays, routine tests, injections, anesthesia, surgery, or other treatment for the health and well being of my child.** I/We agree to be completely responsible for any and all treatment and related costs for medical and dental services provided.

Emergency Contact _____

Emergency Contact _____
Name Address Phone # (s)

Parent or Guardian's Signature _____ **Date** _____

This authorization is valid through: _____ (date)