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)