



Medical Release and Permission Form
Valid for duration of one School year, 13 months (August -August)

Name: _____ Grade: _____ Gender: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____ Birth Date: _____

Immunization Record:

When was the students last tetanus shot? _____

Health History:

Check if these apply to your child.

____ Rheumatic Fever

____ Asthma

____ Epilepsy

____ Diabetes

____ Behavior (Please describe – eg. Bedwetting, nosebleeds, headaches, sleepwalking, etc.) _____

Allergies:

____ Aspirin

____ Penicillin

____ Other Drugs (list) _____

____ Foods(list) _____

Precautions to be observed: _____

Operations or injuries: _____

Current Medication:

Drug:	Purpose:	Dosage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal Insurance Information: Please make a copy of both sides of your insurance card and attach with this form.

Insurance Company: _____ Policy # _____

Group or Employer: _____ Phone # _____

In case of emergency call: _____ Phone: _____

Family Doctor: _____ Phone: _____

In the event of illness, accident, or injury parents are completely responsible for any necessary treatment costs incurred.

If there are any religious or personal objections that do not allow your child to receive a physical exam and/ or immunization, you must give a signed written statement saying that your child is in good health.

Please check one:

____ YES RELIGIOUS/PERSONAL OBJECTIONS ____ NO RELIGIOUS/PERSONAL OBJECTIONS

I hereby certify that the above health record is, as of this date, accurate and complete.

Signature of Parent of Guardian

Date Completed

Witness Signature

Date Completed

I. LIMITED PURPOSE POWER OF ATTORNEY: CONSENT TO TREATMENT OF A MINOR

a. The undersigned hereby appoint:

- Dan Sommer (Pastor of Student Ministries)
- Any official student ministry leader/chaperone

each to act alone, and delegate to each such person the power to consent on our behalf to all emergency treatment and/or medical care (except elective surgery) of _____ (Child's Name) determined to be necessary or desirable by the child's attending physician at the hospital.

b. This Power of Attorney shall continue until revoked by the undersigned, or for (13) months after its date, whichever is earlier. Physicians or the hospital's medical staff may assume and rely that this authorization is currently in effect during such 13 month period unless notified.

II. LIABILITY WAIVER

I recognize that certain hazards and dangers are inherent in the events and programs of The Chapel. I acknowledge that although The Chapel has taken safety measures to minimize the risk of injury to participants, The Chapel cannot insure nor guarantee that the participants, equipment, premises, and/or activities will be free from hazards, accidents, and/or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by the rules, regulations, and procedures for the safety of activity participants.

In consideration of The Chapel accepting and permitting my child to attend this activity, retreat, etc and participate in the activities, I agree that The Chapel, a non-profit corporation, its agents, officers, employees, elders, and volunteers will not be liable for any injury, death, damage and/or loss to my child, and/or anyone claiming on my child's behalf, and I further agree to hold harmless, indemnify and defend The Chapel, its officers, agents, employees, elders, and volunteers for and from any and all damage during the time of my child's attendance and participation with The Chapel, whether such injury, illness, or damage occurs on or off the church premises.

III. PHOTO RELEASE

I certify that photographs or videotape pictures of my child participating in The Chapels programs may be reproduced and utilized in promotional materials for the church

DATED:

Month: _____ Day: _____ Year: _____

Father

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

Employer: _____ Position: _____

Mother

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

Employer: _____ Position: _____

I represent that I am the parent or legal guardian of (child's name) _____, that I am at least eighteen (18) years of age and I am under no mental or legal disability which would prevent me from signing and executing this agreement. I further represent that I have read (or have had read to me) and understood the terms of this agreement.

Father / Guardian Signature

Mother / Guardian Signature

Witness Signature

Date