

# Family Community Church Medical Release form 2018

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Parent/Guardian Cell: \_\_\_\_\_ Other Phone: \_\_\_\_\_

I give permission for the above signed to join and participate in events and/or activities of Family Community Church for the calendar year **2018**.

I hereby release Family Community Church (its staff and sponsors) of any liability for injury or illness that my child may sustain during any activity or transportation.

In the event of an emergency while the above signed minor is participating in events and/or activities of Family Community Church, I authorize Family Community Church staff as agents for the undersigned to consent to any x-ray examination, medical, dental, or surgical diagnosis, treatment, and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, at a doctors office or in any hospital.

I expect to be contacted as soon as possible if any such emergency should occur. I give permission for \_\_\_\_\_ to ride in any vehicle designated by the adult in whose care the minor has been entrusted. In case of accident, we (I) shall be liable for any and all costs and expenses for medical/ dental treatment deemed necessary by a physician.

I will also pick up my child or arrange for his or her transportation home at my expense if the staff or sponsor of Family Community Church ministries deems such action necessary.

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relation to Child: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relation to Child: \_\_\_\_\_

**Medical Information:** List any allergies/medications/illnesses and known physical or mental/emotional challenges: If none, check here: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Members Name: \_\_\_\_\_ Employer: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature Date