

PERMISSION/MEDICAL/INSURANCE RELEASE FORM

Event: _____

Location: _____

Date: _____

I, the undersigned parent or guardian of _____ **[student name]**, do hereby authorize adult workers with the youth of **Grace Community Church, Inc.** to consent on my behalf for the aforementioned student, to any examination, x-ray, anesthetic, medical or surgical diagnosis, or treatment and hospital care which is rendered under supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Further, as parent or guardian of the child named above, I do hereby expressly consent that my child may receive emergency medical treatment from any physician, hospital, or other medical center without the necessity of first notifying me, and do further agree to hold blameless any physician, hospital, or other medical center for rendering such services.

Further, as parent or guardian of the child named above, I do hereby consent to adult workers with the Youth of Grace Church to provide first aid treatment and/or provide over-the-counter medication as they deem necessary, and do further agree to hold blameless Grace Community Church, Inc. and adult workers with the youth for rendering such services.

Further, as parent or guardian of the child named above, I do hereby consent to adult workers with the youth to provide transportation for my child during this activity, and do further agree to hold blameless Grace Community Church, Inc. and adult workers with the youth for rendering such services.

Parent/Guardian Signature: _____ **Date:** _____

INSURANCE INFORMATION

Insurance Company or Group: _____

Policy Number: _____

Parent/Guardian Name [print]: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime #: _____ Cell #: _____ Evening Phone #: _____

Student Cell #: _____ Grade of student: _____

Supplemental Insurance: _____ Policy#: _____

Event: _____

Date Location: _____

Date: _____

Student Name: _____

MEDICAL INFORMATION/PRESCRIPTION MEDICINES/ALLERGIES:

Medical Conditions/Information: _____

Prescription & Non-Prescription Medicines (Include dose and times if applicable): _____

Allergies to Medicines: _____

Allergies to foods/other: _____

Family Doctor: _____ Phone #: _____

Hospital Preference in Reno/Sparks: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Other person(s) Authorized to drive youth to and/or from event:
