



# GREATER GRACE TEMPLE



## Youth Department

### YOUTH MEDICAL RELEASE & PERMISSION FORM

YEAR: \_\_\_\_\_ PROGRAM/ACTIVITY \_\_\_\_\_

Children/Students who fail to comply with the expectations may be sent home/back to parents. Parents will be called to take home children/students who fail to comply with the expectations of participation.

I, \_\_\_\_\_ (child's name) will abide by the stated code of conduct and personal limitations set by the representatives and volunteers of this program/activity.

Student/Child signature or parent/guardian's signature on behalf of child \_\_\_\_\_

Date: \_\_\_\_\_ Parent/Guardian signature \_\_\_\_\_

Programs and Activities may include, but are not limited to Children's Church and Teen Rap (AWANA), recreational participation, games, ice skating, parties, etc. NOTE: if you desire to limit your child/student's participation in any event, please submit your wishes in writing to the church prior to that event.

NAME OF CHILD: \_\_\_\_\_ has permission to attend the specific above listed Children or Teen ministry program/activities sponsored by Greater Grace Temple during the year dated above.

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases Greater Grace Temple, its staff, and its volunteers of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student/child named above, a minor, and have given our consent for him/her to attend events organized by Greater Grace Temple.

I/We understand that there are inherent risks involved in any ministry or athletic event, and I/We hereby release Greater Grace Temple, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement.

In the event that he/she is injured and required the attention of a doctor, I/We consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by Greater Grace Temple, I/We agree to hold such person free and harmless of any claims demands, or suits for damages arising from the giving of such consent.

I/We acknowledge that we will ultimately be responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance information provided below is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above.

I/We also agree to bring my/our children at my/our own expense should they become ill or if deemed necessary by student ministries staff member.

Parent/guardian signature(s): \_\_\_\_\_ Date: \_\_\_\_\_

Student/Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Street Address \_\_\_\_\_ Grade \_\_\_\_\_ Female \_\_\_\_\_ Male \_\_\_\_\_

City, State, Zip \_\_\_\_\_ School \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Work Phone \_\_\_\_\_ Mother's Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Work Phone \_\_\_\_\_ Father's Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Additional Insurance Information \_\_\_\_\_

Dentist \_\_\_\_\_ Office Phone \_\_\_\_\_

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

**Describe in writing and attach to this form** details regarding the nature and severity of any physical and/or psychological ailment, illness, disability, or condition to which your child/student is subject and of which the staff should be aware, and what, **if any action or protection is required** on account thereof. Also include **names of medications and dosages** that must be taken.

**Check the following areas of concern for this student. If necessary, add another page with details:**

For your child's safety and our knowledge, does your child/student have allergies to: **LIST SPECIFIC ALLERGIES**

Food \_\_\_\_\_

Medications \_\_\_\_\_

Insect bites \_\_\_\_\_

Pollens \_\_\_\_\_

**PLEASE NOTE: We provide snacks during some activities so we must be made aware of food allergies**

Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:

For your child's safety and our knowledge, does your child/student have allergies to: **LIST SPECIFIC ALLERGIES**

Asthma

Epilepsy/seizure disorder

Heart Trouble

Diabetes

Frequently upset stomach

Physical Handicap

Date of last tetanus \_\_\_/\_\_\_/\_\_\_

Does your child wear glasses  contact lenses

Please list and explain any major illnesses that child experienced during the last year: