

GRINNELL CHRISTIAN CHURCH DISCIPLINE, LIABILITY AND MEDICAL RELEASE FORM

Today's Date _____ (Date & Initial)

Teenager's Legal Name: _____ Age _____ Sex: M F

Address _____ City _____ State _____ Zip _____

Parent/Legal Guardian's Full Legal Name: _____

Home Phone _____

Mother's Cell _____ Mother's Work Phone _____

Father Cell _____ Father's Work Phone _____

Next Person to Contact if Parents Are Unavailable: Name _____

Relation to the Teenager _____ All Phone Numbers _____

I, the parent or legal guardian of the student listed on this form, certify that he/she has my full approval to participate in Grinnell Christian Church 's youth program activity. The child identified on this form understands that all students are expected to abide by the rules set forth by the youth department and will be directly responsible to the Youth Minister of Grinnell Christian Church. The youth minister assumes the responsibility for discipline at the activity and if necessary, may, because of the misconduct or disobedience, require a student to leave. In such instance, I will assume full responsibility for returning the student home.

Further, I do release and hereby agree to hold Grinnell Christian Church and its employees and agents from any and every claim arising or which may be asserted by me or by any member of my family by reason of participation in any activities associated with the Grinnell Christian Church youth program.

Further, I do authorize the minister or youth leaders of this activity, in the event I cannot be reached by phone, to give consent to a physician and or hospital for emergency medical or surgical treatment while on this trip. It is understood that I will assume any financial responsibility for any expenses that may be incurred for said emergency treatments.

Further, I do certify that said child is covered by adequate accident insurance. My consent and signature is given below. I have read and agree to the information given on this form.

Signature of Parent

or Legal Guardian: _____ **Date:** _____

MEDICAL INFORMATION

1. Family Medical Insurance Carrier: _____ Policy Number: _____

2. List any diseases, physical or mental limitations, or medical conditions. (Asthma, Diabetes, Etc.) _____

3. Allergies (Food, Medication, Insects)? Yes No

If yes, please list: _____

4. Presently taking any prescription or non-prescription medications? Yes No

If yes, what is it and what is the daily dosage: _____

If yes, does your child need adult supervision with their medication? Yes No

5. Are there any other conditions or limitations we should be aware of? Yes No

If yes, please explain: _____