

MEDICAL RELEASE for Events from 12:00 AM DECEMBER 31, 2016 until 11:59 PM DECEMBER 31, 2017

In case of an emergency, I hereby give permission for my child, _____ (full name) to be treated by the physician or hospital selected by any of the adult sponsors of Thrive Christian Church activities.

In consideration of my child being allowed to participate in activities sponsored by Thrive Christian Church, I (we), do for myself (ourselves) and for and on behalf of my child-participant, do hereby release, forever discharge, and agree to hold harmless Thrive Christian Church in Fayetteville Arkansas and its employees, officers, directors, trustees, members, agents, elders, staff, trip sponsors, vehicle owners, and vehicle drivers from any and all liability, claims, or demands for personal injury, sickness, or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child is participating in an activity sponsored by Thrive Christian Church.

We understand that many of the activities will be physical in nature, may include travel and, I (we) and on behalf of my (our) child-participant, hereby assume all risk of personal injury, sickness, death, damage, and expenses as a result of participation in all activities involved therein.

I (we) further agree to allow Thrive Christian Church to use photographs and video recordings of my child-participant to be used in promotional materials and products related to the church and its ministries.

I (we) further hereby agree to hold harmless and indemnify said church, its elders, employees, officers, directors, trustees, members, staff, and agents, (including trip sponsors and vehicle owners) for any liability sustained by said church as the result of negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

I (we) are the parent(s) or legal guardian(s) of this participant, and hereby grant my (our) permission to take said participant to a doctor or hospital and hereby authorize medical treatment, including, but not in limitation to, emergency surgery or medical treatment, and we assume the responsibility of all medical bills, if any.

X _____
Authorized Signature of Parent/Guardian #1

Date

Print Name

X _____
Authorized Signature of Parent/Guardian #2

Date

Print Name

Information

Name of Child _____

Birth Date (Month/Day/Year) _____ Grade _____ Male/Female _____

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

Father's Name _____ Work Phone _____ Cell Phone _____

Mother's Name _____ Work Phone _____ Cell Phone _____

Emergency Contact (In case you cannot be reached)

Name _____ Phone _____ Cell Phone _____

Medical Information

Primary Care Physician _____ Phone _____

Is your child taking any medication (prescription or over the counter)? You MUST list all medications as well as scheduling and dosages provided by your child's physician or by the product's packaging (If necessary use the back).

Is your child allergic to any medicine? Please indicate _____

List any other allergies _____

List any other medical conditions _____

List any surgeries your child has had _____

Insurance Information

Bill sent to: ___ Insurance Company ___ You

Name of person responsible for the bill _____

Name of Health Insurance Company and Address _____

If insurance is through employer, please list the name and address of the employer _____

Whose name is the insurance in? _____

Policy number for health insurance policy _____