



September 1, 2007 - August 31, 2008  
**Medical & Liability Release Form**

Youth's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Sex \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_ SS # \_\_\_\_\_

Grade \_\_\_\_\_

**EMERGENCY CONTACT PERSON:**

Parent/Guardian Name(s) \_\_\_\_\_

Address (if different from student) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Number \_\_\_\_\_

**ALTERNATE CONTACT PERSON:** (Use someone near the primary contact)

Name \_\_\_\_\_ Relationship to Youth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Number \_\_\_\_\_

**INSURANCE INFORMATION:**

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have health insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

Insurance Company Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

In whose name is the insurance? \_\_\_\_\_

Family Doctor \_\_\_\_\_ City/Town \_\_\_\_\_

Phone Number \_\_\_\_\_

**TURN OVER**

**HEALTH HISTORY**

Name and dosage of any medications that must be taken:

Any Allergies? \_\_\_\_\_ To Medications: \_\_\_\_\_

\_\_\_\_\_ Hay Fever      \_\_\_\_\_ Heart Condition      \_\_\_\_\_ Diabetes      \_\_\_\_\_ Insect Stings

\_\_\_\_\_ Asthma      \_\_\_\_\_ Frequent Stomach Upsets      \_\_\_\_\_ Epilepsy/Nervous Disorders

\_\_\_\_\_ Physical Handicap      \_\_\_\_\_ Any major illnesses during the past year?

If any of the above are checked, please give details (i.e. - include normal treatment of allergic reactions)

Date of Last Tetanus Shot \_\_\_\_\_ Contact Lenses? \_\_\_\_\_

Any swimming restrictions? \_\_\_\_\_ Yes      \_\_\_\_\_ No

What? \_\_\_\_\_

Any activity restrictions? \_\_\_\_\_ Yes      \_\_\_\_\_ No

What? \_\_\_\_\_

**LIABILITY RELEASE STATEMENT**

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity dates shown on this form, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, or secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed. Coverage by the Bible Fellowship Church through its accident policy will be used as a backup for what my family's insurance does not cover.

I understand all reasonable safety precautions will be taken at all times by the Bible Fellowship Church of Ephrata and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Bible Fellowship Church of Ephrata, its leaders, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

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

Signature of Student \_\_\_\_\_ Date: \_\_\_\_\_

(if over 18 years of age)