Grace church
1220 Robb Dr. Reno, NV 89523
p: 775.747.9000 f: 775.747.9566
www.gracechurchreno.org

Permission/Medical/Insurance Release Form

I, the undersigned parent or guardian of _____ **[student name],** do hereby authorize adult workers with the student ministry 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 student ministry at Grace Community Church, Inc. 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 student ministry for rendering such services.

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

By signing this waiver, I release Grace Community Church, Inc. from liability on my student regarding any and all official Grace Community Church, Inc. sponsored activities for the year 2017.

Parent/Guardian Signature: _____ Date: _____

INSURANCE INFORMATION

Insurance Company or Group: _____ Policy Number: _____

Supplemental Insurance: _____ Policy Number: _____

Parent/Guardian Name [print]: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Mobile Phone #: _____

Student Mobile #: _____ Grade of Student: _____

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, etc: _____ _____ _____

_____ _____ _____ _____

Family Doctor:_____Phone #: _____

EMERGENCY CONTACT

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Other person(s) authorized to drive student to and/or from events:

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____