LEGACY students

Activity Release and Consent to Medical Treatment

_____ has my permission to attend Student
(Full name of Student)

Ministry activities with Legacy Church during the spring and summer of 2019.

Date of Birth:_____ Age:_____

Home Address:
_____

Consent for Treatment and Release of Liability.

I understand in the event medical intervention is needed, every attempt will be made to contact the persons listed on this form. In the event I cannot be reached in an emergency, I hereby authorize Legacy Church to contact emergency personnel and release pertinent personal information so that my child may receive treatment.

I understand that my health insurance coverage for my child will provide primary coverage in the event medical treatment is needed.

In the unlikely event that my child is injured while participating in activities at Legacy Church, or in route to such activities, my child and I relinquish all rights to recover damages for any and all injuries sustained by my child. I agree to not hold Legacy Church, its leaders, employees, and volunteer staff liable for any damages, losses, diseases, or injuries incurred as a result of the students participation in this activity.

Consent for release of information and for treatment
[ ] *YES* or [ ] *NO*

List allergies, medications currently taken or any other other special conditions we should be aware of:

Will your child be carrying an epi-pen?
[ ] *YES* or [ ] *NO*

Please provide a copy of your health insurance card with this information.

In case of emergency (when the parent/guardian cannot be reached) contact:

NAME:_____ PHONE:_____

Relationship to Child:_____

I give permission for my child to be transported in a vehicle:
[ ] *YES* or [ ] *NO*

I give permission for photos to be taken of my child participating in activities: [ ] *YES* or [ ] *NO*

People who have my permission to pick up my child(ren) when I am unable to:

NAME:_____

PHONE:_____ Relationship to Child:_____

NAME:_____

PHONE:_____ Relationship to Child:_____

_____
_____
Print full name of Mother/Guardian phone number

_____
_____
Print full name of Father/Guardian phone number

_____
_____

I acknowledge that I am the parent or authorized guardian of the above named child. By my signature below, I acknowledge that I have read and understand the information set forth above, including the the ***liability release and consent for treatment*** agreement.

_____
Parent Signature and Date

Please provide a copy of your health insurance card with this information.