



LCC MINOR REGISTRATION AND MEDICAL/LIABILITY RELEASE FORM

2026

Please complete this form and return it to Lebanon Christian Church • P.O. Box 664 • Lebanon, IN 46052/
office@lebanonchristian.org

MINOR'S INFORMATION

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: (____) _____
(If different than parent phone number(s))

Grade: ____ Age: ____ Birthdate: ____ / ____ / ____

School: _____

Gender: Male Female

Has child been baptized by immersion? Yes No

Home Church: _____

If a guest, who invited you? _____

Parents/Guardians: _____

Parent Cell Phone: (____) _____

Family Email: _____



If student is involved in LCC 412 Student Ministries, please fill in the information below:

Student Cell Phone: (____) _____

Texting? _____ Carrier: _____

Student Email: _____

Graduation Year: _____

MEDICAL/LIABILITY RELEASE

As the parent/legal guardian of the above named minor:
(Please check all that apply)

I hereby give my permission for him/her to participate in any and all activities, events, and programs of Lebanon Christian Church. I understand the inherent risks that are involved in these activities and hereby release Lebanon Christian Church, its staff, employees and volunteers from liability for any injury or illness sustained during these activities, events, and/or programs.

I give permission for my child to appear in photographs and videos of church activities, events and/or programs for the use of publication, promotion and documentation, in the form of print or internet usage.

In the case of emergency, I hereby authorize in my absence the adult leader of the activity, event or program, as an agent of me, to consent to any medical treatment, including but not limited to medical, dental, or surgical diagnosis or treatment, x-ray examination, and/or hospital care which is advised and supervised by a medical doctor licensed to practice under the laws of the state where the services are rendered. I give permission with the understanding that a reasonable attempt to contact me has been made prior to any medical treatment.

Name of Parent: _____

Signature of Parent: _____

Date: _____

MEDICAL INFORMATION

Known Allergies: _____

Medications: _____

Other Info/History: _____

Insurance Policy Holder: _____

Insurance Company: _____

Policy Number: _____

Group Number: _____

Non-Parent Emergency Contact: _____

Phone: (____) _____

Relationship to Minor: _____

FOR INTERNAL USE

Rev 12/2024

Received: ____ / ____ / ____

Entered: ____ / ____ / ____

Entered by: _____

Class: _____

Status Change/Date: _____