



# LCC MINOR REGISTRATION AND MEDICAL/LIABILITY RELEASE FORM

2019

Please complete this form and return it to Lebanon Christian Church • 610 W 250 N • 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 12/2018

Received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Entered: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Entered by: \_\_\_\_\_

Class: \_\_\_\_\_

Status Change/Date: \_\_\_\_\_