

**2017 – 2018 STUDENT MINISTRY MEDICAL RELEASE AND PERMISSION FORM**

WELLINGTON CHURCH, NICHOLASVILLE, KY

Valid August 1, 2017 to July 31, 2018

Must be completed in its entirety. Please print clearly. Must be Notarized.

Please attach photocopy of both sides of insurance card.

**Student Information:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_

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

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Parent/Guardian Information:**

Father/Guardian \_\_\_\_\_

Mother/Guardian \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

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

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

Phone (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

Phone (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

(Cell) \_\_\_\_\_

(Cell) \_\_\_\_\_

Additional Contact Person: \_\_\_\_\_ (Phone) \_\_\_\_\_

**Insurance Information:**

Do you have health insurance that covers this student? Yes  No

Name of Insurance \_\_\_\_\_

Company \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

In whose name is this policy? \_\_\_\_\_ Relationship to student \_\_\_\_\_

Family Doctor \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

**Health History:**

Please list any current medical conditions of your student: \_\_\_\_\_

List names and dosages of any medications currently taken by your student: \_\_\_\_\_

List any allergies or severe reactions: (Food) \_\_\_\_\_

(Drugs) \_\_\_\_\_ (Other) \_\_\_\_\_

List any activity restrictions \_\_\_\_\_

**It is the responsibility of the parent/guardian to notify the church if any information under health history changes within the valid year.**

**PERMISSION TO PARTICIPATE AND RECEIVE EMERGENCY MEDICAL CARE, AND RELEASE OF LIABILITY**

The above named student has my permission to participate in student activities of Wellington Church, Nicholasville, Kentucky. This includes travel to and from church sponsored events and meetings. I understand that church staff and event workers will take all reasonable and appropriate steps to protect the health and safety of my son or daughter. In the unlikely event that a serious illness or injury occurs to him or her during an event, every reasonable effort will be made to notify me. In my absence, I authorize appropriate emergency and medical treatment to be provided to my son or daughter. I agree to indemnify and hold harmless the church, its employees, and its agents for any injury, damage, or harm that may occur to my son or daughter while participating in church related activities and related travel.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Date

**NOTARY CERTIFICATION**

I, \_\_\_\_\_, a Notary Public, do hereby certify that on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ there appeared before me \_\_\_\_\_ known to me to be the person whose name is subscribed in this instrument, and who swore and acknowledged to me that he/she executed this instrument for the purpose and in the capacity herein expressed, and that the statements contained herein are true and correct.

\_\_\_\_\_  
Notary Public, State of \_\_\_\_\_

My commission expires \_\_\_\_\_

Seal