Shorewood Church of God
Student Ministries Medical Release Form
2017-2018

Minor Information (Please print)

Full Name of Minor:____

Address:____

City:___________________________________ State:_______________ Zip:________________

Home Phone:________________________ Parent/Guardian Cell:_________________________

Gender:_______________ Date of Birth:__________________ Grade:____________________

School:___________________________________

Parent/Guardian Full Name(s):____

Health Insurance Information:

Health Insurance Company:____

Policy Number:_____________________________ Group Number:______________________

Phone Number:_____________________________

Emergency Contact Information:

In an emergency, please notify one of the following:

1. Name:____________________________________ Relationship to Minor:_______________

   Home Phone:___________________________ Cell Phone:_____________________________

2. Name:____________________________________ Relationship to Minor:_______________

   Home Phone:___________________________ Cell Phone:_____________________________

3. Name:____________________________________ Relationship to Minor:_______________

   Home Phone:___________________________ Cell Phone:_____________________________

Medical History:

Has the Minor had all school required vaccinations? ___ Yes ___ No

Date of last tetanus shot:____________________

Does the Minor have a communicable disease or medical condition that may be a risk to others? ___ Yes ___ No If yes, please describe:____________________________________

____

Does the Minor have any drug allergies? ___ Yes ___ No
If Yes, please describe:____

Please describe any special considerations regarding the Minor (medical conditions, food allergies, dietary restrictions, activity limitations, behavioral issues/concerns, etc.)

____

____

Authorization for Medical Treatment:

As a parent or legal guardian of ______________________ ("Minor") each of the undersigned gives his or her authorization and consent for Shorewood Church of God of Shorewood, IL ("The Church") and the Church's adult employees, agents and volunteers (collectively with the Church, the "Shorewood Church of God Parties") to seek, authorize, and consent to such medical or dental care for Minor ("Treatment") as any one or more of them may deem necessary or appropriate. Such Treatment (1) shall be provided upon the advice of and supervision by a physician, surgeon, dentist, or other medical practitioner licensed to practice under the laws of the state or jurisdiction in which such Treatment is sought, and may include, without limitation, x-ray examination; anesthetic; medical, dental or surgical diagnosis or treatment; and hospital care. Every effort will be made to contact one of the signers of this authorization before treatment is authorized whenever possible. This Authorization for Medical Treatment may be a photocopy hereof and shall be as valid as an original copy. Each of the undersigned acknowledges and agrees that Shorewood Church of God Parties shall not be legally or financially liable for any bill or expense incurred in, or any cause of action or claim arising from, the provision of any Treatment or the failure to provide or seek any Treatment. In consideration on Minor's participation in one or more events sponsored by the Church, each of the undersigned hereby agrees to indemnify, defend, and hold harmless Shorewood Church of God from and against any and all losses, damages, liabilities, or expenses (including without limitation, reasonable attorneys' fees and other costs of defense) in connection with any and all actions, suits, claims, or demands that may be brought or instituted against any Shorewood Church of God Party and arise out of or result from the provision of any Treatment or failure to provide or seek any Treatment. This paragraph shall survive any termination or expiration of the Authorization for Medical Treatment for any reason.

By my signature below I acknowledge this consent is in affect from September 1, 2017 to September 1, 2018

Name: * ____

Signature:____

Date:___________________________

Name: * ____

Signature:____

Date:____________________________

** Note: Each person who has legal custody of Minor should sign this Authorization for Medical Treatment, and only a person who signs will be considered a legal custodian of Minor.*

This form must be Signed and Dated only in the presence of a notary

STATE of Illinois

County of ___________________

Subscribed and sworn to before me on ____________________ day of ____________, 20____

_______________________________________ _______________________________________

Notary Public My commission expires