

**FELLOWSHIP OF THE ROCKIES RELEASE FORM**

Effective for all events from January to December \_\_\_\_\_ (year)

Name of Student \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent's Cell \_\_\_\_\_ Work Phone \_\_\_\_\_

**HEALTH QUESTIONS** (circle & give dates of immunizations or illness)

CPT \_\_\_\_\_; Polio \_\_\_\_\_; Measles/Mumps/Rubella \_\_\_\_\_; Flu \_\_\_\_\_; Rheumatic Fever \_\_\_\_\_; Whooping Cough \_\_\_\_\_; Diabetes \_\_\_\_\_; Chickenpox \_\_\_\_\_; Fainting \_\_\_\_\_; Sinusitis \_\_\_\_\_; Ear Infection \_\_\_\_\_; Asthma \_\_\_\_\_; Kidney Trouble \_\_\_\_\_; Sleepwalking \_\_\_\_\_; Frequent Sore Throats \_\_\_\_\_; Mood Disorders \_\_\_\_\_; HIV positive/Aids \_\_\_\_\_; Other \_\_\_\_\_

Any Operations or serious injuries \_\_\_\_\_

Allergies: Food \_\_\_\_\_; Drugs \_\_\_\_\_; Bee Sting \_\_\_\_\_; Wasp Sting \_\_\_\_\_; Insect Bites \_\_\_\_\_; Other \_\_\_\_\_

Should Student be restricted in any way? \_\_\_\_\_

Has the student been exposed to any communicable disease in the last 21 days? If yes what? \_\_\_\_\_

**PERMISSION FOR MEDICATION**

Please list all medications the student is taking. Including medications for any kind of behavior disorder, etc.

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of day to be given: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_ Possible side effects: \_\_\_\_\_

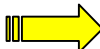
Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of day to be given: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_ Possible side effects: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time of day to be given: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_ Possible side effects: \_\_\_\_\_

I hereby give my permission for my child to take the above medication as directed. I understand that it is my responsibility to furnish this medication in a container appropriately labeled by the pharmacy or physician, stating the child's name, the name of the medication and the dosage. Over-the-counter medications, i.e., vitamins, Tylenol, etc., must also be labeled with the child's name and the dosage.

 Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL RELEASE FORM** (To be completed by parent or guardian)

**\*IMPORTANT\*** If a medical emergency should arise I hereby give permission to the Director/Leader to select a physician and or a hospital for my child's care. I hereby also give the hospital and/or physician, as selected by the Director/Leader my permission to hospitalize, treat, and to order injections, anesthesia, or surgery as needed.

In the event of injury, I agree to be responsible for all medical costs incurred and any insurance necessary. I hereby waive and release any and all claims for damages I, or my family, may have against Fellowship Of The Rockies Church, the other churches involved or any of the participants of the trip or event.

I understand that I am responsible for my child's conduct during this activity and hereby give permission for reasonable corrective measures to be taken should my child need them (including dismissal travel expenses at the parents expense). I understand that I will be assessed reasonable charges for damages to property caused by my child.

Insurance Company \_\_\_\_\_ Group Id \_\_\_\_\_ Policy Number \_\_\_\_\_

 Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_