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: _______________________________

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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 __________________