

FELLOWSHIP OF THE ROCKIES RELEASE FORM

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 _____