First Assembly of God

9427 Maynard Drive • P.O. Box 419
Marcy, New York 13403

PERMISSION TO TREAT/LIABILITY RELEASE

Our church insurance is SECONDARY insurance! If you have medical insurance, your carrier will be billed for medical expenses in the event of illness or injury while your son or daughter is on or at a church related activity.

"In the event that I, the undersigned parent (or guardian) cannot be reached in an emergency during the dates specified on this form, I hereby give my permission to the physician or dentist selected by the church leadership to secure proper treatment, hospitalize, and/or order injections, anesthesia, or surgery for my son or daughter as deemed necessary and appropriate."

"Every activity sponsored by this church is carefully planned and well supervised by mature leaders. However, even with the best of planning and precaution, unforeseen events can occur. By signing this form below, I the parent (or guardian) of the above listed minor, agree to assume and accept all risks and hazards inherent in church-related social activities. I also agree not to hold this church, its employees, or its volunteer staff and assistants liable for damages, losses, or injuries to my child. I understand that I am signing for the minor listed on this form, and my signature indicates a medical as well as a liability release."

Printed Name of Father/guardian Signature of parent/guardian

Printed name of Mother/guardian Signature of parent/guardian

Date signed (This Release Expires January 2017)_____

Printed Full name of Child/Student

Street Address, City, State, Zip (Full mailing address)

Home Telephone Number:

Mom's E-mail Address: Cell Phone Number

Dad's E-mail Address Cell Phone Number

School Grade Date of Birth

(Over)

In case of emergency, parents will be contacted. If unable to reach parents, please call:

1.) Name and relationship Phone Number

2.) Name and relationship Phone Number

Family Physician Phone Number

Current Medications:

Name of Medication & Instructions (Need more room – attach new sheet)

Medical/Health Insurance:

Name of Company

Policy Number Group Number

Full Mailing Address

Name of responsible Party Relationship

Health History:

Allergies:

Penicillin: ☐ Yes ☐ No

Other Drugs:

_____

Insects/Stings or Bites:
☐ Yes ☐ No

Other Conditions:

Other Allergies:_____

Physical Handicaps:_____
Asthma: ☐ Yes ☐ No
Diabetes: ☐ Yes ☐ No
Hay Fever: ☐ Yes ☐ No
Heart: ☐ Yes ☐ No
COMMENTS:
_____
_____
_____
_____

Restrictions: ☐ Yes ☐ No

(List on separate sheet)