INSURANCE INFORMATION

Our Church's insurance is only secondary insurance. If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your son or daughter is involved in a church -related activity.

Do you have health insurance? _______ Yes ______ No

(Please make a copy of your insurance card and attach it to this form.)

Provider: ____ Policy Number: _____________________________

STATEMENT OF RELEASE:

Every youth ministry activity sponsored by this church is carefully planned and supervised by mature adults. However, even with the best of planning and precaution, unforeseen events can occur. By signing this form, the parent of guardian agrees to assume and accept all risks and hazards inherent in church-related activities. He or she agrees not to hold Westlake Community Church of God or its employees or volunteer assistants liable for damages, losses, or injuries to the person named above. He or she also understands that the signature below is for both a medical and liability release.

"In the event that I cannot be reached in an emergency, I hereby give my permission to the physician or dentist selected by Westlake Community Church of God leadership to hospitalize, secure proper treatment, and/or order injection, anesthesia, or surgery for the person named above, as deemed necessary. I also agree to accept full financial responsibility for the cost of such treatments."

Parent or guardian's signature ____ Date _____/______/_____

AUG 13' – AUG 14'

MEDICAL AND LIABILITY RELEASE FORM

Student's Name ____ DOB ____/_____/______
School Grade _________

Student's Cell (   ) ______________________________________

Parent (s)/ Guardian(s) Student Lives with: __________________________ Home/ Cell (   ) __________________

__________________________ Home/ Cell (   )__________________

Student Home Address

____

IN CASE OF EMERGENCY CONTACT: ______________________________________ Phone (   ) ____________________

Doctor: ________________________________ City: ______________________________ Phone (   )____________________

HEALTH HISTORY

Allergies:

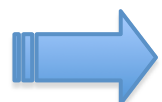
______ Insect stings _______ Drugs (_____________________________) Other Allergies ______________________

Other Conditions: ________ Heart condition ______ Frequent colds _______ Frequent stomach aches

_____ Hay fever ________ Diabetes _______ Physical handicap ______ Chronic Asthma ______ Epilepsy

______ Other (____ ________)

If you checked any of the above, please give details (i.e., include normal treatment of allergic reactions):



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