



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 ____/____/____



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):

Name (s) and dosages of any medications(s) that must be taken: _____

Date of last Tetanus shot: ___/___/___ Can student swim? _____ Yes _____ No

Any activity restrictions? _____ No _____ Yes (_____)

