

Hope Community Church
2009 – 2010 Youth Ministries Medical Release Form
Valid June 1, 2009 – August 31, 2010

MINOR INFORMATION (please print)

Full Name of Minor: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Parent/Guardian Cell Phone/pager: _____

Sex: _____ Date of Birth: ____/____/____ Grade: _____ School: _____

Parent/Guardian Full Name(s): _____

Parent/Guardian email address(es): _____

(Some medical facilities may require a Social Security Number to provide treatment. We will contact you if we need this information)

HEALTH / DENTAL INSURANCE INFORMATION

Health Insurance Company: _____

Policy Number: _____ Group Number: _____

Address _____ Phone Number: _____

Dental Insurance Company: _____

Policy Number: _____ Group Number: _____

Address _____ Phone Number: _____

EMERGENCY CONTACT INFORMATION

In an emergency, please notify one of the following:

1) Name: _____ Relationship to Minor: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone/Pager: _____

2) Name: _____ Relationship to Minor: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone/Pager: _____

MEDICAL HISTORY

Has Minor had all school-required vaccinations? Yes No Date of last tetanus shot: _____

Does Minor have a communicable disease or medical condition that may be a risk to others?
 Yes No If Yes, Please describe: _____

Does Minor have any drug allergies? Yes No If Yes, Please describe: _____

Please describe any special considerations regarding Minor (medical conditions, food allergies, dietary restrictions, activity limitations, behavioral issues/concerns, etc.): _____

AUTHORIZATION FOR MEDICAL TREATMENT

As a parent or legal guardian of _____ (“Minor”), each of the undersigned gives his or her authorization and consent for Hope Community Church of Andover, KS (the “Church”) and the Church’s adult employees, agents, and volunteers (collectively with the Church, the “Hope Community Parties”) to seek, authorize, and consent to such medical or dental care for Minor (“Treatment”) as any one or more of them may deem necessary or appropriate. Such Treatment (1) shall be provided upon the advice of and supervision by a physician, surgeon, dentist, or other medical practitioner licensed to practice under the laws of the state or jurisdiction in which such Treatment is sought, and (2) may include, without limitation, X-ray examination; anesthetic; medical, dental, or surgical diagnosis or treatment; and hospital care. Every effort will be made to contact one of the signers of this authorization before treatment is authorized whenever possible. This Authorization for Medical Treatment may be a photocopy hereof and shall be as valid as an original copy. Each of the undersigned acknowledges and agrees that the Hope Community Church Parties shall not be legally or financially liable for any bill or expense incurred in, or any cause of action or claim arising from, the provision of any Treatment or the failure to provide or seek any Treatment. In consideration on Minor’s participation in one or more events sponsored by the Church, each of the undersigned hereby agrees to indemnify, defend, and hold harmless Hope Community Church from and against any and all losses, damages, liabilities, or expenses (including, without limitation, reasonable attorneys’ fees and other costs of defense) in connection with any and all actions, suits, claims, or demands that may be brought or instituted against any Hope Community Church Party and arise out of or result from the provision of any Treatment or the failure to provide or seek any Treatment. This paragraph shall survive any termination or expiration of the Authorization for Medical Treatment for any reason. By my signature below I acknowledge this consent is in affect from June 1, 2009 until August 31, 2010.

Name: * _____ Signature: _____ Date: _____

Name: * _____ Signature: _____ Date: _____

**Note: Each person who has legal custody of Minor should sign this Authorization for Medical Treatment, and only a person who signs will be considered a legal custodian of Minor.*

(This form must be Signed and Dated only in the presence of a notary)

STATE OF KANSAS)
COUNTY OF Butler)

Subscribed and sworn to before me on _____ day of _____, 200__.

Notary Public

My Commission Expires