FAITH PRESBYTERIAN CHURCH
Medical Information and Participation Release
September 2011 – June 2012

My child, __________________________, has my permission to participate in all Faith Presbyterian Church Youth Ministry events or activities between September 14th, 2010 and June 30th, 2011 including but not limited to the special activities, service projects and small group gatherings. I understand that these events are planned and carried out by qualified leaders who have been through a back ground check by the State of California. Further, the undersigned expressly agrees to hold harmless Faith Presbyterian Church; its employees and agents, for any injury to the minor or damage to his/her or any personal property which may be incurred by or as a result of said participation.

In the event that I can not be reach in an emergency I herby authorize a representative of Faith Presbyterian Church to make arrangements as (s)he considers necessary for this child to receive medical or hospital care, including necessary transportation. Under such circumstances, I further authorize the physician named below to undertake treatment of this child as (s)he deems necessary. In the event that the physician is not available at this time, I authorize such care and treatment to be performed by a licensed physician or surgeon. Any and all financial charges incurred in the event of an emergency are the sole responsibility of the Parent/Guardian of the student or participant listed on this form.

In the event that ANY insurance, medical, or emergency contact information changes, it is the responsibility of the Parent/Student to update the Faith Presbyterian Church Youth Ministry Medial Information and Participation Release Form.

Signature of Parent/Guardian ____________________________________Date______________

Emergency Contact Information

Parent/Guardian #1 __________________ Parent/Guardian #2________________________
Phone/cell _________________________ Phone/cell ________________________________
Alternative Contact. Name ___________________________Phone/cell________________

Medical Information

Physician's Name______________________ Telephone Number______________________
Medical Insurance Co.___________________ Insurance Policy No.____________________
Preferred Hospital____

Allergies and Restrictions: please list all allergies and restrictions

Food restrictions (vegetarian and allergies)____
Medications ____
Environmental ____