

SEQUIM VALLEY NAZARENE

481 CARLSBORG ROAD, SEQUIM, WA 98382 ■ 360-683-8642 ■ WWW.SEQUIMCHURCH.ORG

MEDICAL RELEASE FORM 2016

EFFECTIVE DATES: _____ TO DECEMBER 31, 2016

Sequim Valley Church of the Nazarene must have a signed Medical Release form on file for your child for church sponsored, off-campus events or overnight events and must have parent or guardian signature. This medical release form can be good for an entire calendar year. Please print in ink.

Check for update only

Youth Name: _____ Age: _____ Birth: _____

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

Hm Ph _____ Youth cell: _____ Email: _____

Parent/Guardian Contact Information:

Name: _____ Home: _____ Cell: _____ Email: _____
Select: Mother , Father , Guardian

Name: _____ Home: _____ Cell: _____ Email: _____
Select: Mother , Father , Guardian

Emergency contact: Name: _____ Home: _____ Cell: _____ Email: _____
(if parent is not available):

MEDICAL INFORMATION

Medical insurance company _____ Policy #: _____

Physician _____ Office phone _____

Dentist _____ Office phone _____

Current Medications & Schedule _____

Known allergies _____

Special Dietary needs or food allergies _____

Other needs, medical issues or medical history that we should be made aware of: _____

MEDICAL AND LIABILITY RELEASE STATEMENT

I recognize that there may be occasions where the youth named above may be in need of first aid or emergency medical treatment as a result of an accident, illness, or other health condition or injury. I do hereby give permission for Pastor Jerry Luengen, church staff, or any adult helpers to seek and secure any needed medical attention or treatment for my child. I consent to any medical treatment as deemed necessary by a licensed physician and agree to be financially responsible for such treatment. I agree to hold Pastor Jerry Luengen, church staff, or any adult helpers, and any medical professionals attending to my child free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. Further, I affirm that the health insurance information provided above is accurate as of this date and I will be responsible to submit an updated form if any medical or financial information changes during the effective dates of this document.

Parent/Guardian name

signature

_____/_____/_____
Date