



Generations Church

EMERGENCY MEDICAL CARE / RELEASE FORM

PARTICIPANT'S NAME: FIRST _____ MIDDLE: _____ LAST: _____

ADDRESS: _____ CITY: _____ ZIP: _____

BIRTHDATE: ____/____/____ AGE: _____ PHONE: (____)____-_____

DAD / MOM / GRANDPARENT / GUARDIAN (Please Circle)

NAME: _____ PHONE: (____)____-_____

DAD / MOM / GRANDPARENT / GUARDIAN (Please Circle)

NAME: _____ PHONE: (____)____-_____

PREFERRED METHOD OF CONTACT: TEXT CALL

INSURANCE COMPANY: _____ INS CARD #: _____

DOCTOR'S NAME: _____ PHONE: (____)____-_____ CITY: _____

EMERGENCY CONTACT NAME: _____ PHONE: (____)____-_____

I consent and agree to hold harmless, Generations Church, its agents, employees, and volunteer assistants from all liability claims that I or the church might have arising out of my child/youth's participation in all church events. In the case of accident or injury, I grant permission for the person in charge to see that any and all necessary medical assistance is rendered to the above-named participant. I accept full responsibility for the full cost of any and all medical treatment for injury sustained while participating in the program which is over and above that which is covered by medical insurance. I understand that the medical insurance policy for Generations Church acts in a secondary position to the guardian's insurance. (Generations Church's insurance coverage activates only when the participant is not already covered by personal insurance). I agree to submit all claims to my personal insurance company.

I understand that temporary emergency measures may be necessary to safeguard the participant's health, and I do hereby authorize and request personnel from Generations Church to administer or supervise such treatment and to do any necessary procedure until such time as my child can be safely transported to a doctor or hospital. If it becomes necessary in emergency situations or for disciplinary reasons, for the transportation home of the participant, I will pay the costs involved in travel.

PLEASE LIST any MEDICAL CONDITIONS or ALLERGIES/REACTIONS that may be relevant to a health care professional in the event of an injury:

PLEASE LIST the activity(-ies) that the above-named participant is *not* allowed to participate in:

CAN THE PARTICIPANT SWIM? YES NO

SIGNATURE OF PARENT OR GUARDIAN: _____

DATE: ____/____/____