grace chapel

Thrive Parent Release Form 2010

Only COMPLETELY FILLED in forms will be accepted.

NAME OF PARTICIPANT (printed): ____

NAME OF PARENT OR GUARDIAN (printed):____

In the event of accident or injury to any child of mine (specifically my child named as the "participant") or in the event of illness of any child of mine while in, on, or about the premises of Grace Chapel Boise or while participating in any activity sponsored by or under the auspices of Grace Chapel Boise in the year of 2010. I release full liability and or responsibility from Grace Chapel from any of the below addressed agreements.

1. I hereby voluntarily consent to the furnishing to any of my said children to such medical care, attention and treatment by any hospital, physician or physicians as such hospital, physician or physicians may deem necessary or advisable.

2. I authorize any Youth Leader or adult representative of Grace Chapel to consent to such medical care, attention or treatment.

3. I agree to pay the cost of such medical care, attention or treatment and to indemnify and hold free and harmless of and from any and all liability for such cost Grace Chapel and its Youth Leaders.

4. I agree that in the rare case of accidental death, I will hold free any and all liability from Grace Chapel Boise and its Youth Leaders.

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the State Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

IN CASE OF EMERGENCY CALL:

SIGNATURE OF PARENT/GUARDIAN: ______________________________ DATE:____________

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAM:_________________

INSURANCE CARRIER:____________________________________

POLICY NUMBER:____

ALLERGIES:____

MEDICATIONS TAKEN REGURALY:________________________

ADDITIONAL INFORMATION ABOUT STUDENT: ______________________________