

# Trinity Christian Reformed Church

## WAIVER & MEDICAL RELEASE FORM Fields Trips and Special Events

**Activity:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Depart :** \_\_\_\_\_ **Return:** \_\_\_\_\_  
**Leaders:** \_\_\_\_\_

Name of Child \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Does your child have any severe allergies?(bee stings, food, penicillin, other drugs) YES \_\_\_ NO \_\_\_

If yes, please explain \_\_\_\_\_

Does your child have any life-threatening allergies/conditions? YES \_\_\_ NO \_\_\_

If yes, please explain: \_\_\_\_\_

Is your child bringing any medication with him or her? (Antibiotics, inhalers, Ritalin, etc) YES \_\_\_ NO \_\_\_

If yes, please explain: \_\_\_\_\_

Does your child have any physical, emotional, mental or behavioral concerns or limitations that our leaders should be aware of? YES \_\_\_ NO \_\_\_

If yes, please explain: \_\_\_\_\_

Precautions are taken for the safety and health of your child, but in the event of accident or sickness, Trinity Christian Reformed Church, leaders/volunteers are hereby released from any liability. In the event that your child requires special medication, x-rays or treatment, the parents/guardians will be notified immediately.

Your child must be covered by Provincial Health Insurance or equivalent medical insurance.

Provincial Health Insurance Number: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

### Parent/Guardian's Signature:

Print: \_\_\_\_\_ Date \_\_\_\_\_

Sign: \_\_\_\_\_

Parent Phone Number: \_\_\_\_\_ Cell # \_\_\_\_\_