



# MEDICAL & LIABILITY RELEASE FORM

## GENERAL INFORMATION

Date		Effect Date of Release	
Name (Participant)		D.O.B.	
Address		Weight	
City/State/Zip			
Home Phone		Parental Phone	
Day		Evening	Cell

## EMERGENCY INFORMATION

Responsible Party (or Legal Guardian)		Phone	
		Day	Night
Address (if different)		SSN#	
City/State/Zip			
Participant's Physician (PCP)		Address	Phone
Dentist		Address	Phone
Insurance Carrier		Address	
Policy Number		Group Number	Phone
Alternate Emergency Contact		Phone	
		Day	Evening
			Cell

## HEALTH HISTORY

Allergies:     Drug Allergies     Hay Fever     Insects     Other \_\_\_\_\_

Other Conditions     High Blood Pressure     Cardiac     Chronic Asthma     Physical Disability

Epilepsy     Other \_\_\_\_\_

If you checked any of the above, please give details (include normal treatment of allergic reactions): \_\_\_\_\_

Name and dosages of any medications currently taking and how often they must be taken: \_\_\_\_\_

MAY WE GIVE YOUR CHILD THE FOLLOWING IF NEEDED?    CHILDREN'S TYLENOL     YES     NO    BENADRYL     YES     NO

Activity Restrictions: \_\_\_\_\_

NOTE: Every activity sponsored by Table Rock Fellowship hereafter referred to as TRF is carefully planned and adequately staffed. However, even with the best of planning and precaution, unforeseen events can occur. By signing this form, the participant and/or the legal guardian of the participant agrees to assume and accept all risks and hazards inherent in activities sponsored by TRF. The participant and/or the legal guardian of the participant also agrees not to hold TRF or its employees or volunteers liable for damages, losses, or injuries to the person (participant) named above on this form. The participant and/or the legal guardian of the participant(s) understand that they are signing for the (participant) listed on this form and their signature is for both medical and liability release.

MEDICAL AND LIABILITY RELEASE:  
This health history is correct, so far as I know. In the event I cannot be reached in an emergency during any TRF event, I hereby give my permission to Table Rock Fellowship to hospitalize, to secure proper treatment and/or to order injections, anesthesia, or surgery for my child as deemed necessary. I realize that I will be contacted at the earliest possible moment in case of such emergency.

Signature (legal guardian of minor custodial child) \_\_\_\_\_ Date \_\_\_\_\_