

Peace Lutheran Church

701 West Third St.
Connersville, IN 47331

765-825-7692

Email: peacelutheran64@gmail.com

LIABILITY RELEASE AND EMERGENCY MEDICAL CONSENT FORM

Please PRINT legibly.

I, _____ as parent or legal guardian of
(Your name goes here.) (Circle one of the above)

(Your child's name here.)

Hereby authorize the pastor or recognized youth chaperone(s) of Peace Lutheran Church to authorize emergency medical services for the youth named herein in the event of an accident or injury, understanding that I will also be contacted promptly if such a situation arises.

Emergency treatment expenses will be covered by:

(Insurance company/Health Care Provider)

(Group/plan number, policy number, or member number)

(Name of the employer that carries the insurance or your name if self-insured)

The herein-named youth has the following medical conditions, allergies, and /or take these prescribed medications.

Understanding that Peace Lutheran Church, and its agents and volunteer drivers will take reasonable care, it is hereby understood that my signature below also releases them from any and all liability in the event of an accident, injury, theft, etc. involving this youth.

I understand that any behavior unbecoming of a Christian is grounds for the restriction or return of the youth from youth activities. The parent or guardian may be requested to provide for the return of the youth to his/her home. This release and consent form will remain in force for the dates *July 8 – 12, 2018*, or until amended or revoked in writing by the parent or guardian, whichever comes first.

(Date) signed: _____
() Parent or () Legal Guardian

(Date) signed: _____
(Youth)

Peace Lutheran Church

701 West Third St.
Connersville, IN 47331

765-825-7692

Email: peacelutheran64@gmail.com

LIABILITY RELEASE AND EMERGENCY MEDICAL CONSENT FORM

Please PRINT the following.

Name: _____ Age: _____ Entering Grade: _____

Home Church: _____
(If Applicable)

Home Address:

(street) (city) (state) (zip)

(Home Phone Number) (Cell Phone Number)

(Work Phone Number) (E-mail)

Work Address:

(street) (city) (state) (zip)

(Work Phone Number)

Alternate Person to Contact:

Name: _____ Relationship: _____

Home Address:

(street) (city) (state) (zip)

(Home Phone Number) (Cell Phone Number)

Other special needs your child has:

Your child may be pictured in photos taken during this event. Please sign below **if you do not object** to having your child included in photos.

Parent/Guardian Signature _____ Date _____