# Church Medical Release

1. **Medical Release**

All information provided on this form is correct to the best of my knowledge. In case of emergency or illness, I understand that every effort will be made to contact the Emergency Contact for my child. I give the following individuals: _____

_____ (group leaders names) of _____ (church name) permission to seek medical treatment for my child in case of emergency. I give the above leader(s) permission to provide my child with medical treatment which may include, but is not limited to: the use of Tylenol, Ibuprofen, Benadryl, Rolaids, Cough Medicine, Chlorapheniramine (allergy medication), Benadryl Cream, Caladryl, Triple Antibiotic Ointment, Sudafed, Claritin, or generic equivalents to these medications, physician consultation, urgent, emergency, and non-emergency medical treatment. I agree to indemnify and hold harmless _____ (church name) and it's leaders, staff, employees, members, agents, vehicle owners, vehicle drivers, trip sponsors, board of trustees, and any other parties, including Dare 2 Share Ministries and its leaders, staff, employees, members, agents, vehicle owners, vehicle drivers, trip sponsors, board of trustees, and any other parties, volunteering on behalf of Dare 2 Share from any and all claims, damages, losses, or injuries and expense arising out of or resulting from my child's participation in LTC (Lead The Cause) activities.

Please note any exceptions to treatment: _____

_____

_____

Initials _____

2. **Medical Release and Consent to Emergency Medical Treatment**

I authorize _____ (group leaders names) from _____ (church name), in whose care my child has been entrusted, to consent to any X-Ray examination, diagnosis and/or treatment (i.e. anesthetic, medical, surgical, or dental), or hospital care to be rendered to my child under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether diagnosis or treatment is rendered at the office of a physician or the hospital, I shall be liable and agree to pay all costs and expenses incurred in connection with such medical/dental services rendered. This authority is granted only after a reasonable attempt has been made to contact me or in a life-threatening situation.

Initials _____

3. **Insurance Information**

Insurance subscriber's name _____ (please include a copy of Insurance Card)

Insurance Company _____ Policy # _____

Subscriber's DOB _____/_____/_____ Subscriber's SS# _____

Insurance Billing Address & Phone _____

Primary Physician Name _____ Phone _____

Signed: _____ Date _____
(Parent/Legal Guardian)

Witness: _____ (someone other than immediate family)