

**NEW WORK FELLOWSHIP**  
**Permission and Medical Release Form**

**Student's Name:** \_\_\_\_\_

**Parent or Guardian:** \_\_\_\_\_

I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity dates shown on this form, I hereby give my permission to the physician or dentist selected by the activity leader, or other adults in the group, to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary.

I understand that my insurance coverage for my child will be used as the coverage in the event medical intervention is needed.

I understand all reasonable safety precautions will be taken at all times by the New Work Fellowship Church and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold New Work Fellowship Church, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Student  
(if over 18 years of age) \_\_\_\_\_

Notary Information: \_\_\_\_\_

Signature: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

*Seal*

**MEDICAL RELEASE 2008**  
**NEW WORK FELLOWSHIP**

**(PLEASE PRINT)**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_  
Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Emergency Contact Person:**

Parent/Guardian Name \_\_\_\_\_  
Address (if different from student) \_\_\_\_\_  
Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number (Home) (\_\_\_\_) \_\_\_\_\_ (Work) (\_\_\_\_) \_\_\_\_\_

**Alternate Contact Person:** (Use someone near the primary contact)

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number (Home) (\_\_\_\_) \_\_\_\_\_ (Work) (\_\_\_\_) \_\_\_\_\_

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have health insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of Insurance Co. \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

In whose name is the insurance? \_\_\_\_\_

Family Doctor \_\_\_\_\_ City/Town \_\_\_\_\_

Phone Number \_\_\_\_\_

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the youth ministry activity.

**Health History:**

Pre-existing or present medical conditions

\_\_\_\_\_  
Name and dosage of any medications that must be taken: \_\_\_\_\_

\_\_\_\_\_  
Any allergies? \_\_\_\_\_ To medications? \_\_\_\_\_

\_\_\_\_ Hay Fever \_\_\_\_\_ Heart Condition \_\_\_\_\_ Diabetes \_\_\_\_\_ Insect Stings

\_\_\_\_ Epilepsy/Nervous Disorders \_\_\_\_\_ Asthma \_\_\_\_\_ Frequent Stomach Upsets

\_\_\_\_ Physical Handicap \_\_\_\_\_ Other

\_\_\_\_ Any major illnesses during the past year?

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions)

\_\_\_\_\_  
Date of Last Tetanus Shot \_\_\_\_\_ Contact Lenses? \_\_\_\_\_

Any activity restrictions? \_\_\_\_\_ Yes \_\_\_\_\_ No

What? \_\_\_\_\_