Deltona Alliance Church
921 Deltona Blvd., P.O. Box 5692
Deltona, FL 32728
Phone: 386/574-6046

THIS FORM IS CONFIDENTIAL

MEDICAL INFORMATION AND RELEASE FORM

This form is valid for one year from date of signature. Please notify office of any changes. A copy of this form will be as valid as an original document.

I/We consent to ____ **going to**
(Youth/Child's Name)

A Deltona Alliance Church sponsored event and agree to release and discharge the Deltona Alliance Church, its officers, agents and employees, (all claims, and demands/rights and causes of action) growing out of personal injuries and property damage resulting or occurring during the aforementioned activity, or in transit to and from said activity. I/We further give permission for necessary emergency medical care to be given by a doctor, nurse or other medical personnel while under church supervision.

Medical Info

Youth/Child Social Security Number: ____________________ *Date of Birth:* ____________ *Age:* ____

Insurance Company: ____________________________ *Policy/ID/Group No.:* ________________

Insurance Company Phone Number: (____) _______________ *Member Name:* _______________

- **Please list below ALL medical information a physician might need before medically treating your son/daughter *(allergies, reaction to medicines, asthma, high blood pressure, etc.)***
  (If NONE, please write "NONE"): ____
- **Please list below any medication your son/daughter might be taking during the activities.**
  (If NONE, please write "NONE"): ____
- Family Physician: (_______) ____
  (Name, Office Phone Number and where can be reached)

As the undersigned legal guardian, I do hereby authorize the adult workers of the Deltona Alliance Church, under whose auspices the program is conducted, to secure any emergency medical care and/or treatment that may be necessary during the entire event.

I consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon licensed under the provisions of the ***MEDICAL PRACTICE ACT*** on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Parent/Guardian Printed Name(s):____

Address: ____

(______)______________________________ (______)____________________________________
(Home Phone Number) **(Work Phone Number)**

Email address: ____
Alternative phone number where parent can be reached or other person or relative knowing whereabouts of parent(s): ____

IT IS THE RESPONSIBILITY OF PARENT/GUARDIAN TO INSURE THAT THEY CAN BE CONTACTED IN THE EVENT OF AN EMERGENCY ON THE DATE OF EACH EVENT.

State of ______________________________ **County of** ___________________________

Date ______________________________ 20 _____ ______________________________________
Parent/Guardian Signature

Sworn to (or affirmed) and subscribed before me the ____ day of _______, _________, by ________________________

Personally Known _____ or Produced Identification _____ Type of Identification Produced ______________________

____________________________________ (Notary Stamp)
Notary Signature

(REV 4/30/14)