WAIVER & MEDICAL RELEASE FORM

Appendix 2
Overnight Events

Activity:_____Date:_____

Chaperones:_____

Name of Child:_____ Age:_____

Address:_____

Phone:_____ School:_____

Emergencv/Alternate Phone:_____

Does your child have any severe allergies? (bee stings, food, penicillin, other drugs)
YES _____ NO _____ If yes, explain: _____

Does your child have any life-threatening allergies?
YES _____ NO _____ If yes, explain: _____

Is your child bringing any medication with him/her? (Antibiotics, Ventilator, Ritalin)
YES _____ NO _____ If yes, explain: _____

Does your child have any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of?
YES _____ NO _____ If yes, explain: _____

Precautions are taken for the safety of your child, but in the event of accident or sickness, Trinity Bible Church, its staff, and its volunteers are hereby released from any liability. In the event that your child requires special medication, x-rays or treatment, the parents/guardians will be notified immediately.

Check if your child currently, or within the last three months, has had any of the following:

Appendicitis_____	Ear infection_____	Hay Fever_____	Mumps_____
Asthma_____	Epilepsy_____	Hepatitis_____	Severe Stomach Ache_____
Bedwetting_____	Diabetes_____	Measles (Red) _____	Sinusitis_____
Chicken Pox_____	Fainting_____	Measles (German) _____	
Tonsillitis_____	Other_____		

Date of last Tetanus Shot:_____

Precautions are taken for the safety of your child, but in the event of accident or sickness, Trinity Bible Church, its staff, and its volunteers are hereby released from any liability. In the event that your child requires special medication, x-rays or treatment, the parents/guardians will be notified immediately. In case of surgical emergency, **I hereby give permissions to the physician selected by Trinity Bible Church to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.**

Your child must be covered by Provincial Health Insurance or equivalent medical insurance.

Provincial Health Insurance Number:_____

Name of Family Physician:_____ Physician's Phone:_____

Parent/Guardian's Signature:_____ Date:_____