Name of Minor_____

Medical and Release Form
Evangelical Community Church
503 South High Street Bloomington, IN 47401
Phone (812) 332-0502 Fax (812) 331-8689

I/we give consent for the below named child to attend and participate in the all Evangelical Community Church/Fishack Student Ministries for the entire year of 2014.

I/we authorize an adult, in whose care the minor has been entrusted, to consent to an x-ray examination, anesthetic, medical surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dental 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 or at said hospital. I/we release Evangelical Community Church or other individuals involved of any liability for accidents incurred during any 2014 event.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in the connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for my (our) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Name of Minor_____Age___Birthday_____Home Phone ( )_____

Address_____City_____State_____Zip_____

Name of Parent(s) or Guardian(s)_____

Relation to Minor_____Signed_____Date_____

Contact Info_____

Medical Insurance Co._____

Policy #_____

Family Doctor_____Address_____

Doctor's Phone (___)_____Date of last Tetanus shot_____

List any other medical information, conditions, and allergies:

_____

_____

_____

_____

Other Emergency contacts

Name_____Phone_____Relation to minor_____

Name_____Phone_____Relation to minor_____