PLEASE FILL OUT BOTH SIDES

Valid From 01-01-16 thru 12-31-16

Dayspring Fellowship – Student Ministries

1755 Lockhaven Dr. NE, Keizer, Oregon 97303 Phone: 503-390-3900 Fax: 503-393-3920

MEDICAL & LIABILITY RELEASE FORM

Student Name _____

Address _____ City _____ Zip _____

Home Phone _____ Birth Date _____ Age _____ Gender: M / F

Parent/Guardian Names _____

Dad's Work/Cell # _____ Mom's Work/Cell #_____

IN CASE OF EMERGENCY Persons to notify if unable to reach parent/guardian:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Liability Release Form:

Please sign the following statement if you desire to have your child participate in Dayspring activities.
Every activity sponsored by this church is carefully planned and adequately supervised by mature adults. However, even with the best of planning and precaution, unforeseen events can occur. By signing this form, the parent or guardian agrees to assume and accept all risks and hazards inherent to church-related social activities. They also agree to not hold this church or its employees or volunteer assistants liable for damages, losses, or injuries to the person or property undersigned. The parents or guardians understand that they are signing for the minor listed on this form and the signature is for a liability release.

Emergency Release Statement:

In case of emergency, I understand that every effort will be made to contact me. However, if I cannot be reached, I hereby give permission to the physician selected by Dayspring Fellowship to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named above.

_____ _____

Parent or Guardian Date

Future Updates (to be signed *after* 12-31-16)

The information above is current and correct.

Parent or Guardian_____ Date_____

Parent or Guardian_____ Date_____

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HEALTH RELEASE

Health History:

Allergies: ☐ Insect Stings ☐ Drugs ☐ Food
☐ None ☐ Other Allergies _____

Conditions: ☐ Heart Condition ☐ Frequent Colds ☐ Epilepsy
☐ Frequent Stomach Upsets ☐ Chronic Asthma ☐ Physical Handicap
☐ Hay Fever ☐ Diabetes ☐ None

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

_____

_____

_____

_____

Any Diet Restrictions?_____

_____

_____

_____

Is child under psychiatric care? ____ If yes, please obtain doctor's signed permission to participate in activities.

Health Insurance – ☐ No Insurance

Company Name (if you have insurance) _____Policy number _____

Physician's Name & Phone Number _____

Dentist's Name & Phone Number _____

Date of last boosters: Tetanus _____ Polio _____ Is appendix removed? _____

Name and dosage of any medications that must be taken : See Medication Form

Any swimming restrictions? ☐ No ☐ Yes_____

Any activity restrictions? ☐ No ☐ Yes_____

Any other restrictions? _____

_____

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