Medical Release & Photo Release- Students

337 Waterdam Road ● McMurray, PA 15317 ● www.faithlakeside.com ● Office: 724-941-9035

Complete all sections in ink *(print):*

Name (last, first, middle):		Age	DOB
Street Address	City	State	Zip
Medical Insurance Company		Policy Number	
Insurance Companies Phone Number	Name of Policy Holder		Policy Holder's Phone Number
Physicians Name		Physicians Phone Number	
Dentist Name		Dentist Phone Number	

Medical History
If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include name or medication and dosages that must be taken.

Circle the following areas of concern for this student. If necessary, add another page with details:

Does your child have allergies to: If so, what are they	Pollen	Medications	Food	Insect Bites
Does your child suffer from, Have experience with or being Treated for:	Asthma Upset stomach	Seizures	Heart Trouble Physical Handicap	Diabetes
Does your child wear:	Glasses		Contact Lenses	

Please list and explain any major illnesses your child experienced in the past year

Additional comments:

Please let the youth leader know of any changes to your child's medical record

Emergency Contact Information

Parent or guardian information:

Name(s) | Phone Number

Email Address | Alternate Phone Number

Other Emergency Contacts

Name/Relation | Phone Number

Name/Relation | Phone Number

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff, volunteers and leaders of any liability against personal losses of named child

I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the student ministries staff member.

Parent Name (Sign) | Date

Parent Name (print)

Photo Release

Faith Community Church Lakeside would like to use your child's photograph publically to promote the church. The images may be used in, but not limited to, print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use.

_____Faith Community Church Lakeside has my permission to use my child's photo

_____ Faith Community Church Lakeside **does not** have my permission to use my child's photo

Parent Name (Sign) | Date

Parent Name (print)