

Registration and Medical Consent Form

Lake Community Church Student Ministries

I, _____, authorize that my child _____
(Parent's Name) (Student's Name)

is granted full permission to participate in the events and activities organized by the Student Ministries of Lake Community Church.

I understand that possible risks and dangers may be encountered on any given trip or event, and I the parent, trust the judgment of Lake Community Church, its pastors and staff, and volunteer leaders. In the event of an emergency or injury to my child, I grant permission to Pastor Paul Peterson or a volunteer leader to seek appropriate medical attention for the injury to my child including visits to the emergency room or a doctor, X-Ray examinations, anesthetic and/or other medical/dental needs. In the event of an emergency or injury, the church representative, staff or volunteer will first attempt to contact and consult with the parents and/or emergency contact person provided on this form, and will only continue to seek medical attention without parental consultation if the parent or emergency contact cannot be reached and if the situation is deemed necessary or extremely urgent.

Understanding the above notice, I release Lake Community Church, its pastors and staff, volunteer leaders, and any event staff/volunteers from any and all liability claims for sickness, expenses, damages, medical services and injury, even injury resulting in death.

Event Name: Boating Event

Effective Dates: Sunday, August 26, 2018

Location: Le Homme Dieu Beach - HWY 29 E., Alexandria, MN

Student Information

Name: _____ Age: _____ Grade: _____ Gender: M / F

Address: _____

Date of Birth: _____ Cell Phone: () _____ - _____

Parent Information

Mother's name: _____ Cell Phone: () _____ - _____

Father's name: _____ Cell Phone: () _____ - _____

Optional alternate phone number: () _____ - _____ (home/work)

Address: _____

Email: _____

Emergency Contact Person (other than parents)

Name: _____ Cell Phone: () _____ - _____

Relationship to student: _____

Medical Information

Medical Insurance Provider: _____

Policy number: _____

Food allergies None Yes If yes, list _____

Medications: None Yes If yes, list medication and instructions _____
