

## Permission to Participate and Medical Release Form

I hereby give permission for \_\_\_\_\_ (students name) to attend and participate in the activities/studies/events/retreats/camps/etc. of Waterbrook Bible Fellowship, and to receive any and all medical attention by the church staff, youth volunteers and/or medical professionals in the event of accident, injury or illness. I assume the financial responsibility, if any, for all such treatment.

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Dad's Cell No.

\_\_\_\_\_  
Mom's Cell No.

\_\_\_\_\_  
Dad's Work No.

\_\_\_\_\_  
Mom's Work No.

\_\_\_\_\_  
Name of Primary Insured

\_\_\_\_\_  
Insurance Carrier

\_\_\_\_\_  
Policy No.

\_\_\_\_\_  
Group No.

\_\_\_\_\_  
Name of Family Physician

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Office Tele No

\_\_\_\_\_  
After Hours No

\_\_\_\_\_  
Known Allergies (food, medication, other; \*if none, so state)

\_\_\_\_\_  
Prescribed Medications (Dosage, Time Taken, Special Instructions;\* if no medications, so state)

\_\_\_\_\_  
Pertinent Medical Information (use back of this form if necessary)

\_\_\_\_\_  
Date of last Tetanus injection

Student wears (check all that apply)  Eye Glasses  Contact Lenses  Hearing Aid  \_\_\_\_\_ (other)

The above information is correct and accurate.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Waterbrook Bible Fellowship  
507 Thomas Street  
Wylie Texas 75098  
214-797-7020