FIRST CONGREGATIONAL CHURCH Glen Ellyn UCC

535 Forest Avenue, Glen Ellyn, IL 60137
630-469-3096
www.fccge.org

2015 – 2016 ACTIVITY WAIVER, MEDICAL INFORMATION AND RELEASE

Dear Parent:

This Activity Waiver, Medical Release and Medical Information must be filled out and signed by you before your child can be permitted to participate in any First Congregational Church, youth fellowship activities. (Your children, who are 18 or older, must also sign this form.) Please return the signed form to the Church Office.

Activity Waiver

My child (or children), _____,
may participate in (a) various First Congregational Church of Glen Ellyn ("FCCGE") youth group activities and programs, including transportation, as well as (b) youth organized "unofficial" activities such as gathering for refreshments or socializing before, after or in place of FCCGE sponsored programs, including transportation. I take full responsibility for my child's (or children's) conduct and safety and for my child's (or children's) choice of transportation related to any such activities. I will instruct my child (or children) on the necessary rules of safety and good Christian conduct.

In consideration of my child's (or children's) participation in these activities, I, for myself and my child (or children), my spouse, heirs, successors and assigns, hereby release and discharge First Congregational Church, UCC of Glen Ellyn and all of its officers, employees, agents and volunteers from any and all claims, demands, and causes of action of whatsoever nature which I or my child, (or children), my spouse, heirs, successors and assigns may have against any of them arising out of, connected with or in any way associated with any of these activities, whether official or unofficial, including transportation, and hereby waive any and all such claims, demands and causes of action.

_____ / / _____
Signature of parent/guardian Date
(For children under age of 18)

( ) - ( ) -
_____
Parent/guardian Day Phone Parent/guardian Evening Phone

_____ / / _____
Signature of youth age 18 or older Date
(For children under age of 18)

Medical Release

As parent or guardian of _____, I authorize treatment of my child (or children) by a qualified physician or nurse if medical treatment is needed. I understand that, should a serious or life-threatening emergency arise, initial treatment may be rendered by one of the adult youth group leaders or volunteers, if in the opinion of that individual, delay might endanger his/her life, cause disfigurement or undue discomfort. I have listed all allergies, ongoing medical treatment or medical problems under "Medical Information" which might influence treatment for my child (or children). I will be responsible for all charges incurred for my child's (or children's) treatment. This permission is granted with the understanding that, except in a serious medical emergency, a reasonable effort will be made to contact me prior to treatment.

_____ / / _____
Signature of parent/guardian Date
(For children under age of 18)

(Please complete reverse side as well)

2015 – 2016 Medical Information

Family Information (please print)					
Parents' or Guardian's Names		Parent/Guardian E-mail Address			
Street Address		City		ZIP	
Home Phone		Parent 1 Cell/Work Ph. #		Parent 2 Cell/Work Ph. #	
Names of Emergency/Alternate Contacts (other than parents)		Home Phone		Cell/Work Phone	
		Home Phone		Cell/Work Phone	
Medical Insurance?	Yes _____ No_____	Name of Insured			
Name of Insurance		Name of Employer			
Insurance Policy or Group #		Insurance I.D. #			
Insurance Phone #		Doctor Name/Group			
Family Doctor/Group Phone #		Doctor/Group Address			

Individual Child/Youth Individual Information					
Child/Youth 1 Name		Date of Birth	___/___/___	Date of last Tetanus Shot	___/___/___
If your child is under a physician's care for ongoing treatment?	Medical Condition	Treatment and/or Medications			
Does your child have a serious or life-threatening allergy or allergies?	Allergens	Emergency Treatment Procedure			
Child/Youth 2 Name		Date of Birth	___/___/___	Date of last Tetanus Shot	___/___/___
If your child is under a physician's care for ongoing treatment?	Medical Condition	Treatment and/or Medications			
Does your child have a serious or life-threatening allergy or allergies?	Allergens	Emergency Treatment Procedure			
Child/Youth 3 Name		Date of Birth	___/___/___	Date of last Tetanus Shot	___/___/___
If your child is under a physician's care for ongoing treatment?	Medical Condition	Treatment and/or Medications			
Does your child have a serious or life-threatening allergy or allergies?	Allergens	Emergency Treatment Procedure			

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