

REGISTRATION/PERMISSION/RELEASE & EMERGENCY/MEDICAL INFORMATION FORM

Real Life Ministries. 1866 N. Cecil Road. Post Falls, Idaho 83854. 208-777-7325

Name of Participant _____ Cell Phone _____ Birthdate: ____/____/____
Email Address: _____ Grade: _____ Age: _____
Home Address: _____
Street Address City Zip
Parent/Guardian's Phone: _____ Emergency Contact's Name: _____ & Phone: _____
Physician's Name: _____ Physician's Phone: _____
Insurance Carrier: _____ Policy #: _____
List participant's Allergies information: _____ Severity: _____
Participant's Pertinent Medical Information: _____

Medications needed at the event: **IF MEDS ARE NEEDED PLEASE FILL OUT ATTACHED MEDICAL FORM- THAT ALSO INCLUDES OVER THE COUNTER MEDICATIONS**

Last Tetanus Immunization: _____

I give permission for my child to receive Over-the-counter medications: Y or N (circle) **PLEASE INDICATE ON THE MEDICAL FORM AS WELL.**

THIS RELEASE IS FOR ALL EVENTS PLANNED BY MIDDLE SCHOOL OR HIGH SCHOOL.

For more information please contact Debbie Sexton at dsexton@reallifeministries.com or (208)777-7325 Ext. 7153.

Parental/Guardian Consent for above initialed event(s)

To Whom It May Concern:

I, _____ parent/guardian of the above named participant, do hereby request that the above named minor be permitted to be involved in all activities regarding **MS/HS Events**. I agree and consent to having the ministers, staff members, volunteers, and leaders, under whose auspices the program is conducted, and any other worker in the program approved as parent to secure any emergency medical care or treatment that may be necessary for my youth during the entire length of the program. I further assume all responsibility for their decisions so made, and emergency care or treatment so secured by my youth in the event I cannot be reached.

Authorization to Treat Minor

I, _____ the undersigned Parent/Guardian of the above named minor, do hereby authorize adult workers with the youth of Real Life Ministries, Post Falls, Idaho, as agent(s) for the undersigned, to consent to any examination-ray, anesthetic medical or surgical diagnosis or treatment and hospital care which is rendered under supervision of any physician or surgeon licensed under provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital in the event I cannot be reached.

Waiver of Liability

I, the undersigned Parent/Guardian of the above named minor, do hereby fully and knowledgeably release Real Life Ministries, Post Falls, Idaho a religious corporation of the state of Idaho, its Trustees, members of the Board, and any adult leaders, whether volunteer or professional, from all liability for any accident, injury(s), or death(s) caused to the above named minor person that may grow out of any athletic, recreational, social, or any activity sponsored by or participated in by said religious corporation, and that this Waiver of Liability shall bind heirs, executors, administrators, assigns, and/or other person(s) having control over the affairs of said Minor person.

Media Release

I understand that from time to time, during the school year, newspaper and media personnel cover event activities. In the event that my child is included in a picture or video for use in the newspaper, TV, or online: I grant permission for my child, _____, to be represented in media publications.

By signing you acknowledge that you have read and consent to the terms set forth in the above paragraphs, relating to the youth listed above:

Signature of Parent/Guardian: _____ Dated: _____