Medical and Liability Release Form

Elim Mission Church
405 Broadway Ave S.
Cokato, MN 55321
320-286-2662

Students full name:_____ Date of Birth:_____

Address _____ Student's Phone: _____

I, the undersigned parent or legal guardian of the child named above, do hereby grant my permission and consent for the said child to attend and participate in the events, activities, and meetings of Elim Mission Youth Ministry, both on and off church grounds, including the necessary transportation to and from these events, activities, and meetings.

Permission is granted for my child to receive medical care if: (1) such care is deemed necessary by the persons in charge of the event, activity, or meeting; (2) the proposed medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain my parental consent would reasonably jeopardize the life, health, or well-being of the child affected; (3) I cannot be personally contacted.

I further agree not to hold Elim Mission Church or any of its paid staff or volunteers responsible for any accident that may occur on the way to, from, or during an event, activity, or meeting. I indemnify, defend, and hold harmless Elim Mission Church for all claims made and liabilities assessed against them as a result of any event, activity, or meeting. I release Elim Mission Church and all medical providers from liability in acting on my behalf in this regard and rendering such medical treatment. I assume the risk and financial responsibility for any injury resulting from any event, activity, or meeting.

By signing below, I am acknowledging that I have read through and understand the above statements.

_____ _____
Signature of Parent or Guardian Date

Parent/Guardian's first & last name (print):_____

Cell: _____

Insurance Information:

Email (print):_____

Insurance company name:_____

Policy Holder:_____ Insurance policy number:_____

In Case of an Emergency, Contact:

Name:_____

Cell Phone: _____

Relationship: Parent or Guardian Other Phone: _____

Name: _____

Cell Phone: _____

Relationship:_____ Other Phone: _____

Medical History:

Allergies:_____

Special Health Concerns:_____

Prescription drugs taken at home:_____

Date of last tetanus shot:_____

We give permission to administer over-the-counter-medications: **YES / NO** (e.g. aspirin, Tylenol, Advil, antibiotic ointments, etc.)

Necessary Treatment: _____

Additional Medical Concerns: _____