

# Clearwater First Nazarene Annual Medical/Liability Release

**Instructions:** This form must be filled out in its entirety and to the best of your ability as the parent/guardian of this student. Please note that this is a two page document, with a place for a notary signature and stamp on page two that must be completed. If extra space is needed to complete the medical information, please use the empty space on the back of this form. Do not use another sheet of paper to ensure all information is included on this form.

Student Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Gender \_\_\_\_\_

Address (with city and zip) \_\_\_\_\_

Parent/Guardian Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Emergency/Alt. Contact \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Family Doctor \_\_\_\_\_ Dr. Phone \_\_\_\_\_

Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Past Surgeries \_\_\_\_\_

Known Medical Issues \_\_\_\_\_

Last Tetanus Shot \_\_\_\_\_

## **MEDICAL WAIVER**

As parent/guardian of this student, I certify that this information is complete and accurate to the best of my knowledge. I hereby give permission for my child to receive any over the counter medications except for the following: \_\_\_\_\_ . In the event that I cannot be reached, by signing this form I hereby give permission in the event of illness or injury for the physician or other health care professional selected by the representatives of the **Clearwater First Church of the Nazarene** (heretofore **CFN** ) to order such tests and treatments as is deemed necessary to safeguard the health of my child. I also give authority to above said medical professional to hospitalize, secure proper treatment and order injections and/or anesthesia and/or surgery for my child. In addition, I hereby waive any and all claims, suits, costs, and actions of any kind whatsoever against and hold harmless **CFN** and its representatives due to injury or other damage that may be incurred to this student. I understand that this form will remain on file and active for all **CFN** events my child will participate in for the 2015 calendar year or in the case of medical information changes. I understand that it will be my responsibility to ensure the medical information remains current.

**DAMAGE LIABILITY**

I assume financial responsibility for any damage my child may cause, and for providing transportation home should it become necessary for disciplinary reasons.

**MEDIA WAIVER**

I give **CFN** the right to use video and/or still photography of my child for any appropriate promotional use.

Parent/Guardian Name \_\_\_\_\_  
(Please print legibly)

Parent/Guardian Signature \_\_\_\_\_  
(Must be signed in the presence of a Notary Public)

Before me, A Notary Public, in and for said County and State/Province this \_\_\_\_ day of \_\_\_\_\_ 20\_\_ personally appeared \_\_\_\_\_ and acknowledged execution of the foregoing, in witness, I have hereunto set my hand and Notary Seal.

State/Province of \_\_\_\_\_ County of \_\_\_\_\_

Notary Public Signature \_\_\_\_\_

My Commission expiration date \_\_\_\_/\_\_\_\_/\_\_\_\_

Notary Seal \_\_\_\_\_