

**TRINITY LUTHERAN CHURCH**

206 E. Badger Street, Waupaca, WI 54981

**YOUTH MEDICAL RELEASE AND CONSENT FORM**

(Each participant must complete this form)

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME OF PARENT(S)/GUARDIAN(S): \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ PHONE: \_\_\_\_\_

(Please photocopy insurance cards and include with this form)

CURRENT MEDICATIONS TAKEN BY PARTICIPANT (LIST NAME AND DOSAGE):  
\_\_\_\_\_

HEALTH HISTORY: (MAJOR ILLNESSES, LAST TETANUS SHOT, ALLERGIES, ETC.)  
\_\_\_\_\_  
\_\_\_\_\_

FATHER EMPLOYED AT: \_\_\_\_\_ PHONE: \_\_\_\_\_

MOTHER EMPLOYED AT: \_\_\_\_\_ PHONE: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

RELATIONSHIP TO PARTICIPANT: \_\_\_\_\_

Dear Parent or Guardian:  
This form will be presented to the attending physician if your child needs medical treatment in your absence. This will prevent delay of treatment with your signature and photocopied insurance card.

Parent/Guardian (name) \_\_\_\_\_ "I hereby authorize the treatment, administration of anesthesia and surgical treatment for my child (name) \_\_\_\_\_ in the event of a medical emergency occurring during my absence or when hospital or medical personnel can not contact me. This authorization extends to all medical facilities and personnel regardless of setting, in or out of a medical facility, in the treatment of my minor child."

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date: \_\_\_\_\_

07/27/2009



RELEASE of LIABILITY

In exchange for participate in the activity/event of \_\_\_\_\_  
organized by Trinity Lutheran Church, from the date(s) of: \_\_\_\_\_  
agree for myself and (if applicable) for the members of my family to the  
following.

I recognize that there are certain inherent risks associated with the above  
described activity and I assume full responsibility for personal injury to  
myself and (if applicable) my family members, and further release and  
discharge Trinity Lutheran Church for injury, loss or damage arising out of  
my or my family's use of or presence upon the activity/event fore-  
mentioned, whether caused by myself, my family, Trinity Lutheran Church  
or other third parties.

Student Signature \_\_\_\_\_

Parent (Guardian): print \_\_\_\_\_

Parent (Guardian): signature \_\_\_\_\_

Date: \_\_\_\_\_

TRINITY LUTHERAN CHURCH  
206 Badger Street, Waupaca, WI 54981

**ADULT MEDICAL RELEASE AND CONSENT FORM**

(Each participant must complete this form)

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME OF DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

(Please attach a photocopy of your insurance card)

CURRENT MEDICATIONS TAKEN BY PARTICIPANT (LIST MEDICATION AND DOSAGE):

\_\_\_\_\_

HEALTH HISTORY (MAJOR ILLNESSES, LAST TETANUS SHOT, ALLERGIES, ETC.):

\_\_\_\_\_

EMERGENCY CONTACT INFORMATION:

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE (PRIMARY): \_\_\_\_\_ SECONDARY: \_\_\_\_\_

This form will be presented to the hospital and attending physician if you need medical treatment and are unable to consent. This will prevent the delay of treatment with your signature and photocopied insurance card.

I hereby authorize the treatment, administration of anesthesia and surgical treatment for myself \_\_\_\_\_  
(Print name)

In the event of medical emergency occurring when I can not respond for myself due to injury, accident or illness. This authorization extends to all medical facilities and personnel regardless of setting and/or facility in the treatment of me if I am incapacitated to respond my direct wishes for medical treatment.

\_\_\_\_\_  
Signature of participant Date

\_\_\_\_\_  
Signature of Witness Date

**07/27/2009**



RELEASE of LIABILITY

In exchange for participate in the activity/event of \_\_\_\_\_  
organized by Trinity Lutheran Church, from the date(s) of: \_\_\_\_\_  
agree for myself and (if applicable) for the members of my family to the following.

I recognize that there are certain inherent risks associated with the above  
described activity and I assume full responsibility for personal injury to myself and  
(if applicable) my family members, and further release and discharge Trinity  
Lutheran Church for injury, loss or damage arising out of my or my family's use of  
or presence upon the activity/event fore-mentioned, whether caused by myself,  
my family, Trinity Lutheran Church or other third parties.

Signature: \_\_\_\_\_

Print: \_\_\_\_\_

Date: \_\_\_\_\_