

TFC Connection Medical and Liability Release Form

TFC Connection; 662 7th St.--Phillipsburg, KS 67661-- 785-543-5294

Temporary Medical /Liability Release Form

This form covers TFC activities from May 2009 – May 2010

Youth's Name _____ Youth's Social Security # _____

Address _____ Birth date _____

Parents _____ Home Phone _____

Work Place _____ Phone _____

2nd person to notify in case of emergency _____ PHONE _____

Doctor _____ City _____ Phone _____

- On this _____ day of _____, 200__, I/We the parent(s)/legal guardian(s) of the above named child do hereby delegate to the TFC Connection Staff a "Power of Attorney" for the above named child for the purpose of having custody of our child and my / our consent to any needed emergency / medical treatment of said child.
- In the event that I cannot be reached in an emergency during the dates specified on this form, **I hereby give my permission** to the physician or dentist selected by the TFC Connection Staff to hospitalize, to secure proper treatment, and / or order any injection, anesthesia, or surgery for my son or daughter as deemed necessary.
- I understand that every activity sponsored by TFC Connection is carefully planned and adequately supervised by mature adults. However, even with the best of planning and precaution, unforeseen events can occur. By signing this form, as parent / guardian, I agree to assume and accept all risks and hazards inherent in this ministry-related activity. I also agree not to hold TFC Connection, it's employees or volunteer assistants liable for damages, losses, or injuries to the person or property undersigned. As parent / guardian, I understand that I am signing for the minor named on this form and the signature's are to provide for the medical release, and the liability release.
- **Further, should it be necessary for the participant to return home due to medical reasons, disciplinary action, or otherwise, we (I) hereby assume transportation costs.**

Signature of parent / guardian _____ Date _____

Health History

Allergies to: ___ Insects ___ plants / weeds ___ medications ___ animals ___ other _____

Physical conditions _____

Medications and dosages _____
 ___ Please check here and indicate on the back if more detailed information is necessary.

Date of last tetanus shot _____ **Swimming Ability** ___ Well ___ Fair ___ None at all

List any restrictions (i.e. activities, foods, etc.) _____

Health Insurance Carrier: _____

Policy Number: _____

Agent Name / Address: _____

Parents or Guardians Social Security #: _____

Make a copy of Insurance Card to staple on back.