

REKINDLE 2016 RELEASE FORM

PERSONAL INFORMATION

NAME: _____

AGE: _____ GENDER: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PARENT/GUARDIAN CONTACT PHONE: (_____) _____

ALTERNATE CONTACT PHONE: (_____) _____

I agree to abide by all REKINDLE rules and will assume full responsibility for my physical welfare and will not hold Ambassador Baptist College liable in case of sickness or accident.

Teenager's signature Date

HOME CHURCH INFORMATION

CHURCH NAME: _____

PASTOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MEDICAL INFORMATION

TEENAGER'S PHYSICIAN: _____

PHYSICIAN'S PHONE: (_____) _____

DATE OF BIRTH: _____

DATE OF LAST TETANUS SHOT: _____

PRE-EXISTING MEDICAL CONDITIONS: _____

MEDICATION TAKEN REGULARLY: _____

REASON: _____

ALLERGIES (FOOD, MEDICINE, INSECTS, ETC.): _____

TYPE OF ALLERGIC REACTION: _____

TREATMENT GIVEN: _____

SPECIFIC ACTIVITIES TO BE RESTRICTED: _____

REASON: _____

In case of emergency, I understand that every effort will be made to contact the parents or guardians of teenagers. In the event that I cannot be reached, I hereby give permission to the physician selected by the REKINDLE director to hospitalize and secure proper treatment for and order injection, anesthesia, or surgery for my child. I also affirm that the medical information above is complete and accurate.

Parent/guardian's printed name Parent/guardian's signature Date

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