REKINDLE teenconference

2017 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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Parent/guardian's printed name Parent/guardian's signature Date