Consent to Medical, Dental, or Hospital Care and Release of Liability For The Bridge Fellowship

General Release

By participating in the activities of The Bridge Fellowship, I acknowledge that there may be inherent or other risks involved. I/We agree to release The Bridge Fellowship and its agents from all liability of damage and injury to myself or to the participant indicated below for whom I am the Parent/Legal guardian. I also accept full liability for any loss or damage for all equipment or property of The Bridge Fellowship while it is in my control or possession.

Transportation Release

I/We the undersigned do hereby give permission to The Bridge Fellowship and its agents and representatives to transport the participant named below to and from any program, ministry, or activity sponsored by The Bridge Fellowship and I/We hereby release The Bridge Fellowship, its agents and representatives from any and all liability that may otherwise occur during the course of transporting the below named person to or from a program, ministry or activity.

Medical Release

I/We the undersigned do hereby give authorization to The Bridge Fellowship, its representatives, and agents discretion for obtaining any medical treatment that the representative/agent deems necessary for the person named below leading to, during, or following any program, ministry or activity sponsored by The Bridge Fellowship.

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment.

As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

Student and Parent General Information

Participant's Full Name (Please Print) ____________________

Participant's Address ____________________

City ____________________ State __________ Zip Code __________

Date of Birth: __________ Home Phone Number ____________________

Parent/Guardian Name(s) (Please Print) ____________________

Address ____________________

City ____________________ State __________ Zip Code __________

Cell Phone Number __________ Work Phone Number ____________________

Other Emergency Phone # ____________________

Alternate Contact Person: Name ____________________

Relationship (Aunt, friend, etc.) ____________________ Phone # ____________________

Please continue on the back of this form.

Health Care Information:

Primary Care physician: ______________________________ Phone #: _________________________

Is there medical or hospitalization insurance which provides benefits for this child? Yes No

Name of Policy Holder: _________________________________

Insurance Company: ____

Insurance Address: ____________________________________ City: ____________________

State: _______ Zip: _____________ Phone #: _______________________

Insurance Policy #: _______________________ Group #: __________________________

* **Please provide a copy of the front and back of your insurance card.**

Are there any known allergies (food, medicines, animals, etc.) we should be aware of?

____

____

Are there any significant health conditions we should be aware of?

____

____

Are there any medicines the child is taking we should be aware of? (Please list drug, dosage, frequency)

____

____

(If health condition is of a personal nature you may communicate it to the Ministry Director verbally.)

I certify that I am the parent or legal guardian of the child named above. I further certify that the above information is accurate to the best of my knowledge. I, the undersigned, have read and understand the above medical consent and release from liability for my child through the year 2009.

Parent/Guardian's Signature ____ Date ________________

Participant's Signature ____ Date ________________

(If a minor, signature of parent or guardian is also required)

Sworn To And Subscribed Before Me This______ Day of ______, 20_____.

____

Notary Public

____

My Commission Expires