



Regeneration 2019

July 26 - 30, 2019

Office Use Only

Amount: _____

Payment Type: _____

STUDENT INFORMATION

Name: _____

Male | Female

DOB: _____ | _____ | _____

Grade in Fall: _____

Small group leader: _____

Home church: _____

Home address: _____ City / zip: _____

PARENT INFORMATION

Name(s): _____

Home phone: (_____) _____

Cell: (_____) _____

Email: _____

INSURANCE INFORMATION

(Please attach a copy of your insurance card, front and back)

Insurance Company: _____ Policy/ member number: _____

Group number: _____

Company phone: (_____) _____ Physician's name: _____

MEDICAL HISTORY | CONSENT & RELEASE: (Please mark all that apply)

☐ drug allergies

☐ mental disability

Date of last tetanus:

☐ seizure disorder

☐ insect sting allergies

_____|_____|_____

☐ cardiac problems

☐ physical disability

Special notes: _____

☐ epilepsy

☐ nervous disability

☐ diabetes

☐ other: _____

I hereby authorize the participation of the above-named child in activities of Grace Community Church. In consideration of Grace Community Church providing these activities, I, on behalf of myself and other parents and guardians of the minor, do hereby release Grace Community Church, its officers, employees, agents, and members of the Board of Elders from all claims and causes of action by reason of any injury which may be sustained as a result of these church activities, whether on the church premises or on the way to or from these activities. I agree to direct my child to cooperate and to conform with directions and instructions of personnel of the organization in charge of these activities. Should my child not do so, and should those leading an activity believe it necessary, I will come and remove my child from the activity as soon as possible after being called by a staff representative for that purpose. I understand and agree to leadership having access to my child's room when necessary.

I hereby give my permission to the physician, nurse, or dentist selected by Grace Community Church to secure medical or dental aid as required for illness or injury under a physician's orders, including transportation to and from necessary facilities. As a participant, I understand Grace Community Church is not obligated to carry any insurance to cover those medical and/or dental expenses. If such insurance is carried, coverage will be provided only for expenses in excess of the limits of the participant's insurance. I understand that my personal insurance is my primary coverage. This authorization shall remain effective until revoked in writing delivered to Grace Community Church.

X _____

Signature of parent or legal guardian

_____|_____|_____

Date