TRUE WORSHIP CHRISTIAN FELLOWSHIP

PERMISSION AND MEDICAL AUTHORIZATION FORM

Event Name: **Place:**

Date(s):

Participant Name: _____ Birth date: _____

I give permission for my child to attend the event listed above.

Medical Release

I hereby request and authorize the True Worship Christian Fellowship Staff, hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical or dental care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act for my child.

Custody Release

I further authorize the True Worship Christian Fellowship or designated adult representative to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

Activity Release

I further give permission for my child to participate in all supervised activities except as noted:

_____

_____

Signature of Parent or Legal Guardian **Printed name of Parent or Guardian** **Date**

EMERGENCY CONTACT INFORMATION

Parent/Guardian

Name(s)

Street Address

City State Zip

Phone Numbers	Phone Type (Home, Mobile, etc.)

Other Emergency Contact

Name(s) Relationship to Participant

Phone Numbers	Phone Type (Home, Mobile, etc.)

Dr. Jimmy Arthur Atkins, Senior Pastor
True Worship Christian Fellowship
704-909-8749

HEALTH CARE INFORMATION

Participant Name: _____

Physician	**Dentist**
Name	Name
Phone	Phone
Medical Insurance Company	Dental Insurance Company
Policy/Group Number	Policy/Group Number
Name of Policy Holder	Name of Policy Holder

Please list any allergies to drugs, foods, plants, insects, etc:

Please list any prescription medication (and dosage information) to be taken by the participant:

Please list any non-prescription (over-the-counter) medication you do NOT want dispensed to your child:

Please list any additional information relevant to participating in activities (surgeries; serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or indications, etc.):