**Medical Info/ Activity Release Form**
**Dakota Rock Grove United Methodist Church**

120 S. Church St. Dakota, IL 61018
815-449-2613
Nancy L. Vidad Pastor

GENERAL INFORMATION

NAME:_____

BIRTHDATE:_____SCHOOL GRADE:_____

PARENTS/GUARDIANS:_____

HOME PHONE#:_____WORK/CELL PHONE:_____

EMERGENCY CONTACT (if parents not reachable)_____

RELATIONSHIP TO STUDENT_____PHONE#:_____

MEDICAL INFORMATION:
Please list any medical information that would need attention during this person's participation to any events with us or that would need attention in case of a medical treatment or emergency.

Any past or present health conditions?_____

_____

Any food or drug allergies? _____

Any current medications? _____

Any other information? _____

Permission/Liability Release:
I hereby give permission for_____to participate with Dakota Rock Grove United Methodist Church in the "_____" on_____.
In the event of an emergency and I cannot be reached, I give permission for the participant to receive medical/surgical treatment which is determined by Dakota Rock Grove United Methodist Church and/or the medical/surgical treatment which is determined by Dakota Rock Grove United Methodist Church and/or the medical personnel of any health care facility to be necessary for his/her well-being. I assume all risk which may be involved in the participant's involvement in the activities of Dakota Rock Grove United Methodist Church. I hereby forever release Dakota Rock Grove United Methodist Church, its directors, employees, agents, and members from any liability, claims, or demands of any nature whatsoever which may be incurred while this person is participating in the activities of Dakota Rock Grove United Methodist Church.

Signed:_____

Date:_____ (Parent/Guardian's Signature)