

CONSENT AND MEDICAL RELEASE

I, _____ hereby acknowledge that it is my desire for my child, _____ to participate in church-sponsored activities at Lighthouse World Outreach Center, including activities on and/off the church campus as well as transportation to and from such activities.

MY CHILD IS VOLUNTARILY PARTICIPATING IN THESE ACTIVITIES INCLUDING TRANSPORTATION TO AND FROM SUCH ACTIVITIES, WITH KNOWLEDGE OF THE RISK INVOLVED AND HEREBY AGREE TO ACCEPT ANY AND ALL RISKS OF INJURY AS A RESULT OF SUCH PARTICIPATION AND TRANSPORTATION. As lawful, consideration for permitting me and my child to participate in such activities, including transportation, I hereby release and discharge Lighthouse World Outreach Center, its officers, employees, agents and members of The Official Board from all actions, claims or demands I, my heirs, distributee, guardians and legal representatives now or may have for any injury or damages resulting from acts, howsoever caused, by said church, officers, employees, agents or Official Board during my participation in such church-sponsored activities on and/or off the church campus, including all transportation.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT BY SIGNING THIS FORM I AM RELEASING *LIGHTHOUSE WORLD OUTREACH CENTER, INC.* OR ANY REPRESENTATIVE THEREOF FROM ALL LIABILITY AND DO SO OF MY OWN FREE WILL.

This Consent and Release Form Liability shall remain effective until revoked in writing and delivered to Lighthouse World Outreach Center, Inc. located at 609 Gene Bell Road • P.O. Box 1596 • Monroe, Ga 30655

Signed this _____ day of _____, 20 _____ Print Name _____
Signature: _____ Address: _____
(Parent or Guardian if child is a minor or dependent)
City/State/Zip: _____ Phone: _____

EMERGENCY NOTIFICATION

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Personal Physician: Dr. _____ Phone: _____
Dentist: Dr. _____ Phone: _____

Medical History (Use back of form for any explanations)

Allergies _____ Drugs _____ Asthma _____ Hay Fever _____ Insect Stings _____
Other _____
Health History Diabetes _____ Cardiac _____ Chronic Asthma _____ Epilepsy _____
Physical Handicap _____ Emotional/Mental Handicap _____ Seizures Disorder _____
Activities Restriction _____ Medications _____
Last Date of Tetnus Shot _____ (Booster required every 10 years)
If you have checked any of the above, please give details: _____

The information above is correct to the best of my knowledge. By signing below I understand I am giving my permission to receive (or my child) medical treatment in the event of an emergency by a physician or medical facility selected by *Lighthouse World Outreach Center* if I or an emergency contact cannot be reached. This will also include permission for dental aid and transportation to and from the medical facility. I understand that every attempt will be made to reach the emergency contacts listed above prior to securing treatment except when lifesaving measures are needed.

Name: _____ Date _____
Signature