Bauer Christian Reformed Church

Contact & Medical Form

Students: _____ _____ _____
First Name Last Name Birthday

_____ _____ _____
First Name Last Name Birthday

_____ _____ _____
First Name Last Name Birthday

As the parent or guardian of the students listed above, I give Bauer Christian Reformed Church the authority to obtain medical treatment for the students listed on this document. I further release from any liability Bauer CRC and its leaders in the event of injury while traveling to an event, during an event, or returning from an event. I also give Bauer CRC permission to use any pictures taken during the event of the students listed on this document for advertising purposes.

Parent or Legal Guardian Name: _____

Parent or Legal Guardian Signature: _____ Date: _____

Contact Information:

Address: _____ City : _____ State: _____ Zip: _____

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Medical Information:

Insurance Provider: _____ Doctor: _____

Allergies: _____

_____

Medication/Medical Conditions: _____

_____

_____