WESTSIDE church

Student Information & Medical Release Form

June 1, 2022 – May 31, 2023

Today's Date: ____/____/____

Student's Name: _____ Birth Date: ____/____/_____

School: _____ Grade [2022-23 school year]: _____

Address_____ City _____State _____ Zip _____

Would you like to receive calendars, postcards, and other mailings from West Side Youth? *Yes / No*

Student Cell #: (_____) _____-_____ Text Updates? *Yes / No*

Student Email: _____ Email Updates? *Yes / No*

Parent/Guardian Info:

Name(s): _____ & _____

Cell #: (_____)_____-_____ Cell #: (_____)_____-_____

Text Updates? *Yes / No* Text Updates? *Yes / No*

Email: _____ Email: _____

Email Updates? *Yes / No* Email Updates? *Yes / No*

Medical Information

Insurance Carrier: _____ Policy #: _____

Allergies [including drug reactions]: _____

Regular medications: _____

Photo/Video Release and Waiver:

I hereby authorize the making of photographs, motion pictures, videotapes, recordings, or other memorializing of said events participation therein, and the publication or other use thereof. I hereby waive any right to compensation therefore or any right that he/she otherwise might have to limit or control such making or use.

Medical Release and Waiver:

I authorize my child, _____, to participate in West Side Church Youth activities, and as a condition of his/her being allowed to do so I hereby release and discharge West Side Church and its constituent organizations and its officers, agents, and employees from any and all claims for personal injuries or property damage that he/she may suffer as a result of his/her participation in West Side activities, whether or not such injuries or damages are caused by the negligence (active or passive) of any of the entities or individuals named or described above.

I hereby warrant and represent that he/she is physically fit and capable of taking part in such activities on the basis of advice given to me by his/her duly licensed medical doctor within the last twelve months, and I know of no change in his/her medical condition since receiving such advice that would affect the opinion of said medical doctor. I hereby give consent for medical treatment to be given to

Doctor: _____ Doctor's Phone #: (_____) _____-_____

Additional Information: _____

Parent or Guardian Name *(print)* _____

Parent or Guardian Signature _____ Date ____/_____/____

Best Contact Phone (_____) _____-_____

Emergency Contact (other than parent/guardian)_____Phone # (_____) _____-_____