

**NEW LIFE CHRISTIAN FELLOWSHIP**  
**Medical Authorization and Release Form for 2009**

**Please complete information:**

**General Information**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name of Parent/Guardian: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ (Parent's) Work Phone: \_\_\_\_\_

**Emergency Information**

Do you have any medical restrictions or disabilities that we need to make provision for?  No  Yes  
If yes, please explain \_\_\_\_\_  
Known allergies to medications, pollen, food, etc. \_\_\_\_\_  
Reactions to allergies \_\_\_\_\_  
Has your reaction ever required emergency care?  No  Yes (explain) \_\_\_\_\_  
Do you have any recurrent health problems (chest pains, kidney problems, etc.)?  No  Yes  
Are you presently taking any medications?  No  Yes (explain) \_\_\_\_\_  
Blood type \_\_\_\_\_ Eye glasses prescription \_\_\_\_\_  
Physician's name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Health Ins Co \_\_\_\_\_ Policy # \_\_\_\_\_ Phone Number \_\_\_\_\_  
In the event of an emergency notify: Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

This is to certify that I am the parent or legal guardian of the child named above and that he/she has my permission to attend church sponsored activities of New Life Christian Fellowship throughout the calendar year of 2008.

I hereby release New Life Christian Fellowship, its officers, agents, employees and other representatives from any and all liability for personal injury or property damage resulting from or occurring during any such activity or while in transit to or from the activity.

I authorize and appoint New Life Christian Fellowship, its officers, agents, employees or other representatives to acquire any and all necessary medical treatment for my child while in their care. I also release New Life Christian Fellowship and its said representatives from any liability in connection with such medical treatment. In the event of an emergency situation, I understand that I will be contacted at the earliest possible opportunity.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 2009

\_\_\_\_\_  
Signature of parent or legal guardian  
**(MUST BE SIGNED IN THE PRESENCE OF NOTARY)**

\_\_\_\_\_  
Driver's license number

Sworn to and subscribed before me

this \_\_\_\_\_ day of \_\_\_\_\_, 2009

\_\_\_\_\_  
Notary Public, State of Florida at Large