

# ATTENTION PARENTS: PLEASE READ BEFORE SIGNING

This form MUST be signed before a notary to be valid!

Crosswind Student Ministries

Crosswind Church

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Annual Medical Release and Permission Form

2024 - 2025

Activities may include, but are not limited to: cookouts, boating, water skiing, swimming, basketball, soccer, broom ball, ice skating, volleyball, softball, baseball, camping, skiing, snowboarding, hiking, concerts, Bible studies, miniature golf, hayrides, student conferences and camps, mission trips, rock climbing, service projects, lock-ins, paintball, ziplining, and more. Transportation modes may be public, private vehicle, church vehicles. Note: If you desire to limit your students' participation in any event, please submit your wishes in writing to the CWSM leader prior to that event.

(Printed name of Student) \_\_\_\_\_, has my permission to attend all CWSM activities sponsored by Crosswind Church in Union City, TN from August 1, 2024 - July 31, 2025.

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases Crosswind Church in Union City, TN, its staff, and volunteer leaders of any liability against personal injury or losses of named student. I/we the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by Crosswind Church in Union City, TN. I/we understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by Crosswind Church in Union City, TN, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/we also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our expense should they become ill or if deemed necessary by the student ministries staff member. I/we agree to submit updated insurance information if our provider/coverage changes. I/we give permission to include my/our student in any videos and/or photographs taken during the course of my student's involvement. I/we agree that a photocopy of this document shall be a legally binding document.

Parent/guardian's Name(print): \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Stamp:**

**Notary Signature:** \_\_\_\_\_

Effective Dates: 8/1/2024 - 7/31/2025

**Student Name:** \_\_\_\_\_

Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

Male  Female

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_.

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Medical Insurance Company:** \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Birthday: \_\_\_\_\_

Contact Number: \_\_\_\_\_

**Mother's &/or Guardian Name:** \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Father's Name&/or Guardian Name:** \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Additional Emergency Contact Name:** \_\_\_\_\_

Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Should this student's activity be restricted for any reason?  Yes  No

(If yes, use the back of the sheet to explain.)

List medication currently being taken:

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Physician: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_

Office Phone: \_\_\_\_\_

**Medical History:** If necessary, describe in detail the nature and severity of any physical and /or psychological ailment, illness, limitation, handicap, disability, or condition to which your child is subject and to which the staff should be aware, and what, if any action of protection is required on account of thereof. Submit this notification in writing and attach to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, add another page with details: Does your child have any allergies (i.e. pollens, medications, food, insect bites, etc)?  Yes  No

If yes, please describe allergy and treatment:

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Does your student suffer from or has ever experienced, or is being treated for any of the following:

- asthma
- epilepsy/seizure disorder
- heart trouble
- diabetes

If yes, please explain:

**Student Consent of Rules:** For your information, we expect each student to conform to these general rules of conduct: No possession or use of alcohol, drugs, or tobacco. No students can drive. No fighting, weapons, fireworks, lighters, etc. No offensive or immodest clothing. No boys in girls quarters, no girls in boys quarters, no PDA (Public/private displays of affection) Participation with the group is expected. Respect others property. Respect one another, staff, and adult leaders. Comply with specific event schedules and rules. Seatbelts must be worn in all vehicles. Students who fail to comply with these expectations may be sent home at their parents' expense. I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in student group activities. I agree to abide by the stated personal limitations and code of conduct.

Student's name (printed): \_\_\_\_\_

Date: \_\_\_\_\_

Student's signature: \_\_\_\_\_