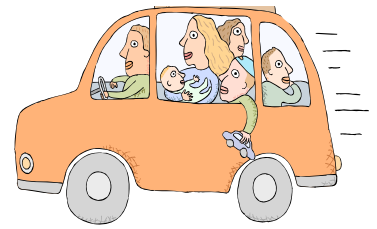


Vineyard Community Church

Medical Release and Liability Forms



I/WE HEREBY GIVE PERMISSION FOR _____
Name of Child

TO WITH VINEYARD COMMUNITY CHURCH on _____ (name date(s)) to
participate in and attend: _____ (name event)
_____ (name destination(s))

It is my understanding that my child will also be transported by walking or by car/van and I hereby grant permission for such transportation.

In the event that my child becomes ill or sustains an injury while in the charge of the Vineyard Community Church, I wish to be notified promptly. If it is not possible to contact us, I/we give permission to those in charge to take whatever steps necessary to administer emergency first aid, and further give my permission for my child to receive emergency medical/surgical care as deemed necessary by any duly licensed physician/practitioner, to administer necessary treatment required for the relief of pain and to preserve his/her life and health. I authorize the emergency medical/surgical treatment of my child at said physician's office, or at a licensed medical hospital.

I also acknowledge that I will not hold Vineyard Community Church responsible for any injuries that my son or daughter receives while being transported or while participating in the facilities.

Parent(s)name: _____
Home address: _____
Home phone: _____ Work phone: _____
Cell phone/pager: _____

In case you cannot be reached in an emergency, please list the name and number of a close relative or friend we can contact.

Name: _____ Relationship: _____
Address: _____
Home phone: _____ Work phone: _____
Cell phone/pager: _____

Parent Signature: _____ Date: _____

SPECIAL INSTRUCTIONS OR SPECIAL NEEDS: _____

MEDICAL CONSENT FORM

FOR MEDICAL/SURGICAL/EMERGENCY TREATMENT

In presenting my son/daughter for diagnosis and treatment

Name: _____ for _____
Mother Father Legal Guardian Son Daughter

of _____ years of age; hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, and blood transfusions, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

I have read this form and I certify that I understand its contents.

We/I hereby give my consent to _____
Name of Person/Agency

Who will be caring for our (my) child _____
Name of Child

For the period _____ to _____ to arrange for routine or emergency medical/surgical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

MEDICAL INFORMATION

Name: _____ Family Physician: _____

Address: _____ Pediatrician: _____

Surgeon: _____

Telephone No. _____ Orthopedist: _____

Name of Health Insurance Carrier: _____ Child's Allergies, if any: _____

_____ Date of last tetanus booster _____

Group No. _____

List medicines child is taking or special conditions: _____

Signature: _____ Date: _____

Witness: _____ Date: _____