



1202 W. Oxford
Enid, Ok 73705
(580) 233-1818

Activity Release Form

Parent/Legal Guardian Consent, Medical Release and Wavier

I, _____ the parent or legal guardian
of _____, give permission for him/her to
Child's Printed Name

participate in the following activity:

Type of Activity: _____

Location of Event: City/State _____

Departure: Date _____ Time _____

THROUGH

Return: Date _____ Time _____

In the event of an accident requiring emergency care and parent/legal guardian cannot be reached, I hereby authorize; any X-ray examination, anesthetic, dental, medical, or surgical, diagnosis and or treatment by any physician or dentist licensed by the state of Oklahoma, or another state within the United States, and hospital service that may be rendered to said minor(s) under the general, specific or special consent of any representative of Central Assembly of God of legal age, the temporary custodian of said minor; whether such diagnosis or treatment is rendered in the office of the physician or dentist, or at a hospital licensed by the same state as the physician/dentist rendering the services. ***I, as the parent/legal guardian, assume all financial responsibility.***

I/We authorize the physician/dentist to call in any necessary consultants, in his/her discretion. I/We understand that this consent is given in advance of any specific diagnosis or treatment, and is given to encourage those persons who have temporary custody of said minor, and said physician or dentist to exercise his/her/their besyt judgement as to the requirements of such medical and/or dental diagnosis, treatment, or surgery.

I/We give permission for a representative for a representative of Central Assembly of God to transport the above listed minor. I/We also understand that Central Assembly of God and it's representatives assume no responsibility incase of accident or illness.

Parent/Legal Guardian Printed Name

Signature

Date

Name of Parent/Guardian _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____

Medical/Health Insurance Company _____

Insurance Policy # _____

In case of an emergency and I cannot be reached, please contact:

Name _____ Phone # _____
Print

Relationship _____

Medical Information:

Allergies/Allergic reactions of my child _____

Medicine being taken by my child _____

Other information regarding my child's health that a doctor should know:

Please check here if you ***DO NOT*** want your child's picture(s) during this event published.