Word of Life Florida ● 13247 Word of Life Dr ● Hudson, Fl ● 34669 ● 727-856-2787

SPECIAL EVENTS
MEDICAL PERMISSION FORM

A parent or guardian for each attendee under 18 years of age is to complete, sign, and date this form. Please bring form to Event.

Please Print

ATTENDEE'S LAST NAME	FIRST NAME	MIDDLE INITIAL

	DATE OF BIRTH	AGE	MALE	FEMALE	

Group Information:	
Group Name:	**Group Leader Name:**
Group City, State:	**Group Leader's Cell #:**

Parent or Guardian		**Telephone Numbers With Area Codes**
	Name:	Home ( )
	Address	Work ( )
	City **State**	**Zip code**

IF NOT AVAILABLE IN AN EMERGENCY NOTIFY: (PREFERABLY RELATIVES)	**Telephone Numbers With Area Codes**
Name	( )
Name	( )

Family Health Insurance Information	Name of Insurance Company	Policy/Group Number
	Parent/Guardian Name (Required by Medical Facilities if under 18 years old)	Telephone Number
		( )
	Parents/Guardian	

SPECIAL MEDICAL PROBLEMS, CONDITIONS OR RESTRICTIONS:

Word of Life Fellowship & Camps are a non-profit charitable organization dependent on God and His people. Those who use Word of Life's facilities and/or engage in related activities, waive and release Word of Life Fellowship from any claim for personal injury or property damage. Attendees agree to carry insurance or have the resources to cover the expenses related to personal injury or property damage.

The health and immunization history is correct so far as I know. My son/daughter has permission to engage in all prescribed event activities except as noted by me and the examining physician. I realize that my child's picture and/or testimony may be used in the future promotion of Word of Life.

Illegal drugs, weapons and similar items are not permitted at camp. Word of Life reserves the right to search for and remove such items from anyone suspected of possessing them.

I hereby give permission to the medical personnel selected by the Word of Life director to order x-rays, routine tests and treatment for my son/daughter, in the event I cannot be reached I hereby give permission to the physician selected by the Word of Life director to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for my child as named above. **This form may be photocopied for Medical Providers' use.**

Signature of Parent or Guardian:_____**Date:**_____

Rev. 2/14