INSURANCE FORM
2015-2016

Fill it out once and you don't have to worry about it till next year!
We require an insurance form for every out of state or overnight activity.

My, child, ________________________________has my permission to attend all activities associated with the *Trinity Church of the Nazarene*.

Authorization to consent to treatment of minor

We (I) the undersigned parent(s) of ______________________________a minor, so hereby authorize *Trinity Church of the Nazarene* as agent(s) for the undersigned to consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general of special supervision of any physician and surgeon under license, under the provisions of the Medicine Practice Act on the medical staff of any Clinic or Hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital or clinic.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any physician in the exercise of his best judgment may deem advisable.

Approval of parents or guardian and waiver of claim

I hereby approve this application and certify to its correctness and expressly waive all claims against *Trinity Church of the Nazarene*, or any of its boards or representatives because of any injury or other damage that may be incurred to the applicant named on this paper or said applicant's property in connection with or incident at church authorized and sanctioned functions.

Signature of parent/guardian____

Address:____
____

Phone:__________________ Work phone:___________________
Cell Phone: ________________

In case of emergency please notify:_________________Phone:__________________

Insurance Number:______________________________
Insurance Company:____________________________

Family Doctor:______________________Phone:___________________

More Information on back

THIS FORM IS TO BE FILLED OUT BY THE PARENT ONLY!!!!

Student's name:_______________________________________

Please indicate any of the following information that pertains to minor

____ Contact lenses	____ Hyperactivity	____ Sleep walking
____ Eye glasses	____ Hyperventilate	____ Sleep wetting
____ Braces	____ Heart ________________	____ Homesickness
____ Hearing aid	____ Kidney ________________	____ Epilepsy
____ Diabetic	____ Learning disability	____ Asthma

____ Other physical or emotional conditions and/or handicaps______________________________
____

____ Medications student is currently taking and for what purpose___________________________
____

____ Surgeries student has had ____

____ Fears student has that may be of concern ____

____ Food allergies
____

____ Medical allergies__________
____ Animal/insect/ environmental allergies
Date of last tetanus shot ________________________

List all prescription and over-counter medications that child has with him/her (Include ear and eye drops, stomach and headache aids, inhaler, cough syrup, etc…)
____

Other important information
____
____

Parent's Signature: ______________________________
Date:___________________