

2017-2018 THE BRIDGE Medical History & Liability Release Form

This Medical Release covers all events and sponsored field trip of The Bridge for the 2017-2018 school year.

Name _____ Date of Birth _____ Age _____ Gender _____

Address _____ Grade for School Year 2017-2018 _____

City _____ State _____ Zip _____ Home Phone _____

Parents Names _____

Work Phone (Dad) _____ (Mom) _____

E-Mail (Dad) _____ (Mom) _____

Family Physician _____ Phone Number _____

Family Insurance Company _____ Policy Number _____

In the event of an emergency, give the name and phone number of friends or relatives we can contact who will know how to reach parents or guardians. **You MUST complete this information.**

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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Past Medical History

(Check giving appropriate information)

**Sinusitis Bronchitis Kidney Trouble Heart Trouble Diabetes
Dizziness Stomach Upset Hay Fever Allergies Asthma**

Allergies: Food _____

(list type) Drugs _____

Insect Stings/Bites _____

Immunizations Tetanus Polio Booster Measles Mumps (Check if Current)

Previous operations or serious illnesses _____

Any current medications (list) _____

Special Diet _____

Any other special instructions regarding child: _____

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Permission and Release

My permission is granted for The Bridge staff members or the designated/approved Bridge Volunteers to obtain necessary medical attention in case of sickness or injury to my child, _____.

I, the undersigned, do hereby verify that the above information is correct and I do hereby release and forever discharge The Bridge and its staff/representatives, from any and all claims, demands, actions, or cause of action, past, present or future arising out of any damage of injury while employed by or participating in any The Bridge event.

I further grant permission for my child to accompany The Bridge a on approved field trips of The Bridge and to ride in approved vehicles with The Bridge approved drivers.

The rights, powers, and authority of said representatives to exercise any and all of the rights and powers herein granted shall commence and be in full force and effect on the date listed below, and such rights, powers and authority shall remain in full force and effect thereafter until revoked by me in writing.

I have supplied, understood, and agree to all the information contained on this Medical Release Form.

Parent/Guardian Signature _____ Date _____

STATE OF FLORIDA COUNTY OF _____

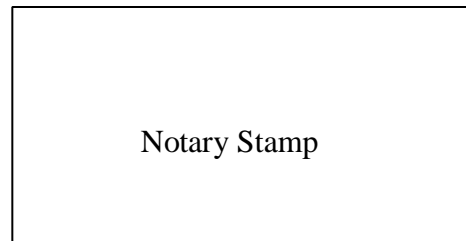
The foregoing instrument was acknowledged before me this _____ day of _____, _____.

By _____

Notary Signature _____

Personally known _____ OR Produced Identification _____

Type of Identification Produced _____



Notary Stamp