RCC Students
Medical Release & Liability Waiver Form

Effective September 1, 2023 through August 31, 2024

Student Name: _____ **Current Grade in School:** _____
Date of Birth: _____ **Phone:** _____
Address: _____
Parent/Guardian Email: _____

I give my permission for my child (named above) to go with *Rockingham Christian Church, Salem, NH,* on RCC - sponsored activities. I release *Rockingham Christian Church,* and its staff and volunteer leaders, from responsibility and liability for any injury or illness that my child/children may sustain during these activities. I also authorize RCC to utilize any photographs and video from said activities for any lawful purpose, such as publicity, advertising, and web content.

IN CASE OF EMERGENCY, I hereby authorize an adult leader of this activity, as an agent for me, to consent to any X-ray examination; medical, dental, or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state or country where the services are rendered, either at a doctors office or in any hospital. I expect to be contacted as soon as possible and before hospitalization or surgery is administered (unless the injury or illness is life threatening).

Signature of parent/legal guardian: _____

MEDICAL INFORMATION

Allergies ***to food:*** _____ ***to insect bites/stings*****:** _____
_____ ***to medications:*** _____ ***to others (list):***
_____ _____ _____
_____

Medications taken currently: _____

Date of last Tetanus Booster: _____ **(must be within the last 10 years)** Please *cross out* any medication you **do not** allow your child to have:

Pain Relievers (Tylenol/Acetaminophen, Ibuprofen, aspirin, other _____)
Allergy Medication (Benadryl, other antihistamines, other _____)
Cough Suppressants (_____)
Decongestants (Sudafed, other _____)
Anti-diarrhea Medications (Pepto Bismol, Immodium, other _____) Other over the counter medications (_____) Physical limitations/Current health conditions: _____

Physician's Name: _____
Address: _____
Telephone Number: _____

INSURANCE INFORMATION

Insurance Company: _____
Name of Insured: _____
Policy #: _____ Group #: _____ Phone #: _____

EMERGENCY CONTACT INFORMATION

Print name of parent/legal guardian: _____
Phone #s of parent/legal guardian: Home _____ Work _____
Cell _____

Names of other emergency contact person(s) and phone number(s):

1st _____

Phone Number(s): _____

_____

2nd _____

Phone Number(s): _____

_____