KENILWORTH GOSPEL CHAPEL-MEDICAL RELEASE FORM

Child(ren)'s Names Date of Birth (mm/dd/yy)

_____

_____

_____

_____

Address _____

Home Phone# _____ Cell Phone # _____

Emergency contact in case parents cannot be reached:

_____

Name Relationship to child Phone #

I GIVE PERMISSION FOR MY CHILD(REN) TO ATTEND AND TO PARTICIPATE IN THE ACTIVITIES AT KENILWORTH GOSPEL CHAPEL. IN CASE OF MEDICAL EMERGENCY, EVERY EFFORT WILL BE MADE TO CONTACT ME. HOWEVER, IF I CANNOT BE REACHED, I GIVE MY PERMISSION TO THE STAFF AT KENILWORTH GOSPEL CHAPEL TO SECURE THE SERVICES OF EMERGENCY PERSONNEL/LICENSED PHYSICIANS TO PROVIDE THE NECESSARY CARE, INCLUDING ANESTHESIA, SURGERY OR HOSPITILIZATION (IF NECESSARY) FOR MY CHILD(REN)'S WELL BEING.

Medical Insurance Carrier: _____

Policy #: _____

Hospital: _____

Allergies/Medical Issues: _____

I UNDERSTAND THAT KENILWORTH GOSPEL CHAPEL, THE VACATION BIBLE SCHOOL PROGRAM AND ITS STAFF ARE NOT HELD RESPONSIBLE FOR ANY MONETARY INCURRENCE FOR SAID MEDICAL TREATMENT.

_____

Parent's signature Date

If before June 22nd, please mail this completed form to the address below. Otherwise, fill it out and bring it with you the first day of VBS: Kenilworth Gospel Chapel, VBS Registration, 557 Newark Avenue, Kenilworth, NJ 07033