fellowship
of CHAMPIONS

Fellowship of Champions Medical and Liability Release Form

This form gives group leaders authorization to secure medical aid for your child should it be necessary during a church related event.

I, _____ consent to allow my child(ren):
(Parent or Guardian **Signature** - First, Last)

_____
(**Print** Minor's name – First, Last)

_____
(**Print** Minor's name – First, Last)

_____
(**Print** Minor's name – First, Last)

_____
(**Print** Minor's name – First, Last)

to be under the care of Fellowship of Champions. I hereby authorize any hospital, clinic, physician; doctor, nurse, or technician to furnish my child(ren), named above, any medical care and treatment necessary as a result of injuries sustained or other emergency medical care treatment as the circumstances require while being transported from and back to the church and while at the place of destination. I hereby authorize representatives of Fellowship of Champions to retain or acquire said medical care and treatment on my behalf if I cannot be reached by telephone or there is not time or opportunity to make such a telephone call. I agree not to hold such a person responsible for any damages arising from the giving of such consent.

This the _____ day of _____ , 202_____.

Fellowship of Champions
16707 Squyres Road, Spring, Texas 77379
281.376.2027

Parent or Guardian Contact Information

_____ (Parent/ Guardian Name – First, Last)

_____ (Parent Signature)

_____ (Address)

_____ (Address)

_____ (Mobile Telephone Number)

_____ (Additional Telephone Number)

_____ (Preferred email address for communication)

Please fill out the following information:

Alternate Emergency Contact _____

and Phone Number _____

Alternate Emergency Contact _____

and Phone Number _____

Is/are your youth covered by medical/hospitalization insurance? ___ Yes ___ No

Are all of your children covered under the same insurance? ___ Yes ___ No

If no, please fill out on next page.

If yes, the following information is necessary:

Name of Primary Insured _____

Insurance Company Name _____

Insurance Company Phone Number _____

Insurance Company Address _____

Group and Policy Number _____

Insurance Carrier's Birth Date _____

If applicable:

Mother/ Guardian Place of Employment _____

and Business Phone Number _____

Father/ Guardian Place of Employment _____

and Business Phone Number _____

Child: _____ Date of Birth: _____

Please list any allergies, medications, or special medical problems.

_____

Child: _____ Date of Birth: _____

Please list any allergies, medications, or special medical problems.

_____

Child: _____ Date of Birth: _____

Please list any allergies, medications, or special medical problems.

_____

Additional Insurance:

_____

_____

_____

_____

_____

****** The insurance carrier's social security number or insurance ID number may be required, per request of hospitals, for admittance. This information will be obtained by the hospital in the event your child needs to receive medical attention. If you have further questions, please contact Jessica Perez at (281) 825-6283 or michelle@fellowshipofchampions.com.

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