



4877 Central College Road, Westerville, Ohio 43081 – 614-939-2100

Annual Parental Permission and Student Medical Release Form

_____ (student's name) has my permission to attend all officially scheduled youth activities of Quest Community Church (QCC) for the year beginning January 1, _____ and ending on December 31, _____. I the undersigned have legal custody of the named above minor, and have given my consent for him/her to attend events being organized by QCC. I understand that there are inherent risks involved in any ministry or athletic event, and I hereby release Quest Community Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to persons or property that may occur during the course of my child's involvement. In the event that he/she is injured and requires the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the church, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by health insurance provider. Further, I affirm that the health insurance information provided below is accurate at this date and will, to the best of my knowledge, still be in force for the student named above and it is my responsibility to ensure that the information is up to date. I also agree to provide transportation at my own expense should they become ill or if it is deemed necessary by the student ministry staff member or volunteer worker.

Today's Date

Signature of father, mother, or legal guardian

Student's Full: _____ **Grade:** __ **Birth date:** __/__/__ **Age:** __

MEDICAL INFORMATION

Current medication: _____ Allergies: _____

Any adverse reactions to medication: _____

Family Doctor: _____ Phone: _____

Regular Dentist: _____ Phone: _____

Health Insurance Co: _____ Policy #: _____

Preferred Hospital: _____ Address: _____

Full name of son/daughter: _____ Grade: _____ Birth date: __/__/__ Age: _____

CONTACT INFORMATION

Father/Mother or Legal Guardian: _____

Home Address: _____ Zip Code: _____

Father/Legal Guardian Cell Phone #: _____

Mother/Legal Guardian Cell Phone #: _____

If unable to reach parent/guardian, please call: _____

Relationship: _____ Phone #: _____