



## Medical & Liability Release Form

P.O. Box 1208  
Kinder, LA 70648  
Phone: 337-390-9441  
Fax: 337-738-3063

Please Print Clearly:

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Church \_\_\_\_\_

Family Physician \_\_\_\_\_ Physician Phone \_\_\_\_\_

Present Medication \_\_\_\_\_

Allergies \_\_\_\_\_

Do you have (circle) Asthma      Diabetes      Epilepsy      Heart Trouble      Thyroid Trouble

If Other, please list: \_\_\_\_\_

Please list any additional information needed: \_\_\_\_\_

**If individual is covered by any type of medical insurance policy, please list:**

Name of Insurance \_\_\_\_\_ Policy or ID # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

**By signing this Medical & Liability Release Form I hereby release Grand Church, Inc. and staff/volunteers/directors from all liability to person(s) and or property and grant permission to a medical facility to administer any medical treatment deemed necessary in the case of any medical need and or emergency.**

Applicant/Participant \_\_\_\_\_ Date \_\_\_\_\_

(Signature of Applicant/Participant)

\*Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

(Signature of Parent/Guardian if under 18 years of age)