

New Life Medical Release Form

Name: _____ **D.O.B.** _____

In Case of Emergency notify: _____

Contact Phone No. : _____

Address: _____

Family Physician: _____

Insurance Company: _____

Policy No.: _____

Allergies: _____

Current Medications: _____

My permission is granted for the Director of Collegiate Ministry to obtain necessary medical attention in case of sickness or an emergency medical situation.

I do hereby verify that the above information is correct, and I do hereby release New Life Fellowship from any and all claims, demands, actions, or cause of action, past, present, or future arising out of any damage or injury while participating in this trip.

Signature: _____ Date: _____

This form is for the _____ trip starting
_____ and returning _____ .