

# Woodlands Lutheran Church Youth Ministry Individual Registration & Medical Information Form

Name (Last, First, MI) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone \_\_\_\_\_ Cell \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Youth Email \_\_\_\_\_ Parent Email \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell \_\_\_\_\_  
Father's Name \_\_\_\_\_ Cell \_\_\_\_\_  
Other Emergency Contact \_\_\_\_\_  
Relationship to Youth \_\_\_\_\_ Phone \_\_\_\_\_

## Emergency & Health Information (if yes, please provide explanation and pertinent information)

Date of last tetanus shot \_\_\_\_\_  
Name/Phone of Doctor \_\_\_\_\_

Do you have:

\_\_\_\_\_ Allergies \_\_\_\_\_  
\_\_\_\_\_ Heart Condition \_\_\_\_\_  
\_\_\_\_\_ Diabetes \_\_\_\_\_  
\_\_\_\_\_ Other \_\_\_\_\_

Do you have a reaction to:

\_\_\_\_\_ Bee Stings \_\_\_\_\_ Penicillin \_\_\_\_\_ Other Drugs \_\_\_\_\_  
\_\_\_\_\_ Plants \_\_\_\_\_ Other \_\_\_\_\_

Are you subject to:

\_\_\_\_\_ Headaches \_\_\_\_\_ Seizures \_\_\_\_\_ Fainting \_\_\_\_\_ Sleep Walking \_\_\_\_\_ Asthma

Any serious illness surgery in the past 10 years \_\_\_\_\_

Any condition that would prevent participation in activities \_\_\_\_\_

Any drugs ineffective in treatment \_\_\_\_\_

Sight or hearing impaired \_\_\_\_\_

Please list all medications currently being used \_\_\_\_\_

Please indicate anything else that would be important for adult leaders to know in case of emergency \_\_\_\_\_

Any special needs \_\_\_\_\_

I will participate fully in all Woodlands Lutheran Church activities and seek to help others do the same.

\_\_\_\_\_  
Youth Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# Medical & Liability Release Form

## Release of All Claims

(To be completed by adult participant and the parent/guardian of youth participants)

In consideration for participation in **all Woodlands Lutheran Church activities**, we (I), being 21 years of age or older, do for ourselves (myself) (and for and on behalf my child-participant if said child is not 21 years of age or older) do hereby release, forever discharge and agree to hold harmless the Florida/Georgia District of the Lutheran Church Missouri Synod, the Lutheran Church-Missouri Synod, and Woodlands Lutheran Church and the leaders and directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child is participating during the above-described year.

Furthermore, (I) [and on behalf of our (my) child-participant if under age of 21 years] hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein.

Further, authorization and permission is hereby given to said church to furnish any necessary transportation, food and lodging to this participant.

The undersigned further hereby agree to hold harmless and indemnify the above organization, its directors, employees, and agents, for any liability sustained by said church as a result of the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

(If the participant has not attained the age of 21 years):

We (I) are the parent(s) or legal guardian(s) of this participant, and hereby grant our (my) permission for him (her) to participate fully during said year, and hereby give our (my) permission to take said participant to a doctor or hospital and hereby authorize medical and/or dental treatment, including but not in limitation to emergency surgery or medical and/or dental treatment, and assume the responsibility of all medical/dental bills, in any.

Further, should it be necessary for the participant to return home due to medical reasons, disciplinary action or otherwise, we (I) hereby assume all transportation costs.

**This release will remain in effect for a period of 12 months from signed date**\_\_\_\_\_.

\_\_\_\_\_  
Type or Print Full Name of Participant

\_\_\_\_\_  
(Father Printed)

\_\_\_\_\_  
(Father Signature)

\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
(Mother Printed)

\_\_\_\_\_  
(Mother Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Legal Guardian)

\_\_\_\_\_  
(Participant, if age 21 or older)

Hospital Insurance \_\_\_\_\_ Yes \_\_\_\_\_ No

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_