

Student Medical Emergency Release Form (S.M.E.R.F.) 2010-2011

Chapel by the Lake
11024 Auke Lake Way
Juneau, AK 99801
Chapelbythelake.org

Jessica Hoffman, Youth Director
Church Phone: 789-7592 Ext. 226
Cell: 907-723-0090
Email: jessica@chapelbythelake.org

*By filling out this form, you give permission for your teen to participate in programs or activities authorized by, and carried out under, supervision of the Youth Ministry of Chapel by the Lake Presbyterian Church for the time period of **October 1, 2011 to October 1, 2012** and so authorize any emergency medical treatment necessary as a result of participation in the programs or activities.*

I, _____ the parent/guardian of _____

Date of birth _____ Grade _____ School _____,

give permission for _____ to participate in Chapel by the Lake Presbyterian Church Youth group programs and activities for the time period of **October 2011 to October 2012** and accept full responsibility for my teen's participation. I also authorize my teen to ride in any vehicle designated by a youth's program leader and consent to any emergency X-ray examination, medical diagnosis or any treatment that may be necessary, provided it shall be under the direction of our family physician, OR, if it is not practical to reach our family physician, any nurse, emergency medical technician, or physician licensed to practice medicine.

Parent/Guardian #1 Information

Name _____

Relationship _____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Email/fax/pager _____

Child resides with Guardian #1(circle one)

YES NO Part time

Parent/Guardian #2 Information

Name _____

Relationship _____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Email/fax/pager _____

Child resides with Guardian #2(circle one)

YES NO Part time

(Signed)

(Date)

(Signed)

(Date)

Alternate person to contact if I cannot be reached, relationship to youth and their phone:

Name _____ Relationship _____ Phone _____

Medical/Health Insurance Company: _____

Policy or Group #: _____ other info _____

Family Physician: _____ Phone #'s: _____

Additional comments regarding medical history, allergies, penicillin or drug reactions, etc. which may be needed in any treatment:

PLEASE LET US KNOW AS SOON AS ANY INFORMATION CHANGES! THANK YOU!