

**CHAPEL HILL CHRISTIAN & MISSIONARY ALLIANCE CHURCH STUDENT  
MINISTRIES DEPARTMENT  
RELEASE OF LIABILITY  
MEDICAL RELEASE**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
HOME TELEPHONE NO.: \_\_\_\_\_ WORK/CELL TELEPHONE NO.: \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_

MEDICAL INSURANCE CO.: \_\_\_\_\_ POLICY NO. \_\_\_\_\_  
FAMILY PHYSICIAN: \_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_  
PERSON TO NOTIFY: \_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_

I, the undersigned Parent/Guardian of \_\_\_\_\_ (Student) hereby release, acquit and discharge Chapel Hill Church of the Christian & Missionary Alliance (CHC) and the Student Ministries Department of CHC (FUSED), and any and all Pastors, staff, sponsors, representatives, employees, and/or agents of CHC and/or FUSED. from any and all liability for any and all damages, losses, illnesses and/or injuries that the above named Student may incur during any scheduled FUSED sponsored activities from June 1, 2011 through May 31, 2012. I understand that for each FUSED sponsored and scheduled event, I shall be provided a separate Parental Activity Consent Form, without which the Student will not be able to participate in any such FUSED sponsored and scheduled event.

In the event of an emergency where medical treatment is or becomes necessary and is required, then and in that event I hereby authorize the Youth Pastor, Youth Sponsor, and/or any other duly appointed representative of CHC/FUSED to consent to any emergency and other medical, dental treatment and/or diagnosis, X-ray, test, and/or hospital care, advised and supervised by a physician, surgeon, and/or dentist licensed to practice under the laws of the state where the services are rendered, either at a doctor's office, clinic, emergency care facility and/or hospital. The undersigned hereby further agrees to pay for and be responsible for any and all costs and fees associated with any such medical treatment that may be rendered to the Student as provided herein.

I hereby understand that I may revoke this authorization by notifying CHC and/or FUSED, in writing, of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I understand that the information used or disclosed by operation of this Release may be subject to re-disclosure by CHC and/or FUSED, and would then no longer be protected by federal privacy regulations. This Release is intended to be in compliance with the federal HIPAA privacy regulations.

List allergies, medications being taken and special medical problems (physical, emotional, mental, and behavioral concerns or limitations): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

(NOTE: If there is a change in the information during the given time period, it is the parent/guardian's responsibility to inform the Chapel Hill Youth pastor of the change.)

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian)