

Loudoun Valley Church of the Nazarene  
35834 Charles Town Pike  
Purcellville, VA 20132  
540 668-6357

## Medical Release Form

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**Student's Name**

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**Age & Birthday**

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**Address**

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**Home Phone**

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**Parent/Guardian's Name**

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**Phone Day**

**Phone Evening**

**Cell Phone**

### MEDICAL INFORMATION

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**Health Insurance Company**

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**Policy Number**

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**Doctor's Name**

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**Phone**

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**Allergies/Special Needs**

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**Person to contact in case of emergency**

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**Phone**

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**Parent Signature**

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**Date**

# RELEASE FORM

We, the parents/guardians give my/our permission for my/our child, \_\_\_\_\_, to participate in all activities of the Loudoun Valley Church of the Nazarene. I/we assume all risks associated with such participation including transportation. I/we hereby release, absolve, indemnify, waive and agree to hold harmless transporting my/our child to and from activities for any claim arising from an injury to my/our child.

\_\_\_\_\_  
Mother's Signature

\_\_\_\_\_  
Father's Signature

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

Both parents must sign, unless only one parent has legal custody. In such case, please indicate non-custodial parent's name and whether to contact in case of emergency.

\_\_\_\_\_  
Non-custodial Parent

\_\_\_\_\_  
Phone

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## EMERGENCY MEDICAL TREATMENT

In the event of an illness or an accident which requires immediate medical treatment, I/we give permission for personnel of LOUDOUN VALLEY CHURCH OF THE NAZARENE to obtain and authorize such treatment for my/our child \_\_\_\_\_ (child's name).

I further understand that if my child needs to be transported to an Emergency Treatment Facility that decision will be made by the Emergency Team who responds to the call. I will not hold LOUDOUN VALLEY CHURCH OF THE NAZARENE, its staff personnel, nor medical personnel responsible.

LOUDOUN VALLEY CHURCH OF THE NAZARENE will immediately notify parents/guardians of the child, in an emergency situation.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

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

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

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

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

\_\_\_\_\_  
Name of Physician

\_\_\_\_\_  
Phone

Hospital Preference: \_\_\_\_\_