

CORNERSTONE BIBLE CHURCH - 2019 WOMEN'S RETREAT
RELEASE AND MEDICAL CONSENT FORM
NOVEMBER 1-3, 2019

NAME: _____
 PHONE: _____
 ADDRESS: _____

EMERGENCY NOTIFICATION	ALTERNATE CONTACT
NAME:	NAME:
RELATIONSHIP:	RELATIONSHIP:
PHONE:	PHONE:

PLEASE LIST EACH FAMILY MEMBER (Including yourself)

FIRST NAME					
DOB					
INSURANCE					
POLICY #					

MEDICAL HISTORY

ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INSECT STINGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHRONIC ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NERVOUS DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PHYSICAL HANDICAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL/EMOTIONAL HANDICAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURE DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRUG ALLERGIES					
OTHER ALLERGIES					
DATE OF LAST TETANUS SHOT					

If you have checked any of the above, please give details: _____

Activity restriction, if any: _____

This health history is correct, so far as I know. I hereby give my permission to the physician, nurse, or dentist selected by Cornerstone Bible Church to secure medical or dental aid as required for illness or injury under a physician's orders, including transportation to and from the necessary facilities. As a participant, I understand Cornerstone Bible Church is not obligated to carry any insurance to cover those medical and/or dental expenses. If such insurance is carried, coverage will be provided only for expenses in excess of the limits of the participant's insurance. I understand that my personal insurance is my primary coverage.

I desire to participate in activities at Cornerstone Bible Church. In consideration of Cornerstone Bible Church providing these activities, I do hereby release Cornerstone Bible Church, its officers, employees, agents, and members of the Board of Elders from all claims and causes of action by reason of any injury which may be sustained as a result of these church activities, whether on the church premises or on the way to or from these activities. I understand and agree that leadership will have access to my room at all times.

This authorization shall remain effective until revoked in writing delivered to Cornerstone Bible Church.

Executed this _____ day of _____, 20____, in _____, CA.

Signature: _____