**NLCC INSURANCE & LIABILITY WAIVER FORM**

**STUDENT NAME**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Last

*Valid January of 2023 through December 2024*

**STUDENT** **BASIC INFORMATION**

 **Gender (check one):** *Male*\_\_\_ or *Female*\_\_\_ **Date of Birth:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ **Current Grade**: \_\_\_\_\_\_\_

 Month Day Year

**School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street and / or P.O. Box # City State Zip Code

**PARENT / GUARDIAN CONTACT INFORMATION**

**[Father’s] Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **[Mother’s] Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Name Last Name First Name Last Name

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street and / or P.O. Box # Street and / or P.O. Box #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip City State Zip

**Primary Phone:** (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ **Primary Phone:** (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

 **Known Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Special Needs:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Current Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Special Medical Info:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Physician Name :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

**Company Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ins. Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If no insurance, check box: \*TURN OVER, Read AND Sign to Complete Validity on BACK\***

**EMERGENCY CONTACT INFO**—IN CASE OF AN EMERGENCY, PARENT/GUARDIAN INFO WILL BE CONTACTED 1ST, THEN:

 **2nd :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

 First Name Last Name Relationship Primary Phone Number

 **3rd :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

 First Name Last Name Relationship Primary Phone Number

**PHOTO / VIDEO RELEASE**

**I understand that New Life Christian Church often uses photographs and video footage for its activities, promotional material, and website. I grant New Life Christian Church permission to use my child’s likeness and the likeness of my family through photographs or video in its publications and website without payment or other consideration.**

 **INITIAL BOX IF YOU PREFER YOUR CHILD’S IMAGE NOT TO BE USED:**

**Please write explanation below:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LIABILITY / EMERGENCY POLICY**

**I, the undersigned, give my permission for my child (named on the front of this form) to attend and participate in events sponsored by New Life Christian Church/New Life Student Ministry. I give permission for my child to ride in any vehicle designated by the adult in whose care has been entrusted while attending and participating in activities sponsored by New Life Christian Church/New Life Student Ministry. I release New Life Christian Church, its staff, and sponsors from responsibility and liability for any injury or illness that my child may sustain during this trip. I also release adults on the trip to treat minor first aid and headaches with over the counter medication unless noted in the Medical Information segment on the front of this form.**

**IN CASE OF AN EMERGENCY**

**I, the undersigned, hereby authorize any adult leader, in whose care the minor child has been entrusted, to consent to emergency medical or dental treatment and hospital care to be rendered to my child (named on the front of this form), to be treated by a physician, surgeon, or dentist while still maintaining responsibility for my child’s health and exempting either the New Life Christian Church or any of its representatives from any other responsibility. I expect to be contacted as soon as possible and before hospitalization or surgery is administered (unless the injury / illness is life-threatening).**

**By signing, I agree that I have read through all the information and**

**completed this form to the best of my knowledge.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

PARENT / GUARDIAN **SIGNATURE**  **PRINT** FIRST AND LAST NAME HERE Month Day Year

New Life Christian Church | 1910 County Road 82 SE Alexandria, MN 56308 | 320-763-7051