



The Rock of Winter Haven
 Student Medical Release/Permission Form
 Effective Dates: 3/22/2026-3/21/2026

Please print neatly in ink

Name: _____ Date of Birth: _____

LAST FIRST MIDDLE MM/DD/YYYY

Male Female Grade: _____ Email address: _____

Address _____ City _____ State _____ Zip _____

Phone _____ Alternate Phone _____

Medical Insurance Company _____ Policy # _____

Mother's Name _____ Phone (Home) _____ (Work/Cell) _____

Father's Name _____ Phone (Home) _____ (Work/Cell) _____

Emergency Contact _____ Phone (Home) _____ (Work/Cell) _____

Physician _____ Office Phone _____

Dentist _____ Office Phone _____

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any, action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for your student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student's swimming: good fair poor

2. Does your child have allergies to: pollens medications food insect bites

If you checked any boxes, identify the specific allergy: _____

3. Does your child suffer from, ever experience, or is being treated currently for any of the following:

- Asthma Epilepsy/seizure disorder Heart trouble Diabetes
- Frequent Upset Stomach Physical Handicap

4. Date of last tetanus shot _____

5. Does your child use vision correction? Glasses Contact Lenses

Please List any major illness your child experienced in the last 12 months:

If your student's activities must be restricted for any reason, please explain:

ADDITIONAL PORTIONS OF THIS FORM MUST BE COMPLETED ON THE OTHER SIDE.

ALL STUDENTS ARE EXPECTED TO COMPLY TO THE FOLLOWING RULES OF CONDUCT:

(Student must initial each line)

_____ No fighting, weapons, fireworks, lighters, or explosives

_____ No offensive or immodest clothing

_____ Participation with the group is expected

_____ Respect property

_____ Respect one another, staff and adult leaders

_____ Respect and comply with event schedules

_____ **Students who fail to comply with these expectations may be sent home at their parents' expense.**

I, the student, have read the rules of conduct, the evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and the code of conduct.

Student Signature: _____ Date Signed: _____

Activities may include, but are not limited to: cookouts, boating, water skiing, swimming, basketball, roller skating, rollerblading, games in the park, soccer, camp fires, ice skating, volleyball, softball, baseball, camping, hiking, biking, golfing, miniature golf, hayrides, concerts, Bible studies. Note: if you desire to limit your child's participation in any event, please submit your wishes in writing to the leader prior to that event.

_____ has my permission to attend all youth activities

NAME OF STUDENT

sponsored by The Rock of Winter Haven (hereinafter "the Church") for the dates indicated on the other side of this form. This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I/we the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of consent. I/we also acknowledge that I/we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided on the front page is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our expense should they become ill or if deemed necessary by a Kidz Cove staff member.

Parent/Guardian Signature(s): _____ Date Signed: _____

STATE OF FLORIDA, COUNTY OF POLK

I hereby certify that the foregoing was executed before me this _____ day of _____, 20____

The above parent/guardian is personally known to me ____, or produced _____ as identification.

Notary Public

My commission expires