

Family Last Name: \_\_\_\_\_

## MEDICAL AND EMERGENCY INFORMATION

### MEDICAL INFORMATION

Please list any allergies or medical conditions that your student(s) may have:

Name of Student:

Allergies/Conditions:

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

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

### EMERGENCY INFORMATION

Please tell us where to reach the following people in case of an emergency:

◆ Parents: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

◆ Close Friend or  
Family Member: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Student(s): \_\_\_\_\_

◆ Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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## MEDICAL RELEASE AND LIABILITY WAIVER

I/We, the parents/guardians of \_\_\_\_\_  
("our children"), hereby give my/our approval for our children to participate in Home School University's  
("HSU's") programs, inside and outside of the Community Fellowship Church premises. I/we assume all risks  
and hazards incidental to such participation by my/our children.

I/We do hereby waive and relinquish any and all claims that I/we or my/our child may have against Home  
School University and its board, directors, members, employees, volunteers, instructors, and assigns, as a  
result of participating in any HSU programs. I/We hereby fully release and discharge HSU and its board,  
directors, members, employees, volunteers, instructors, and assigns from any and all claims from injuries,  
damages, or loss which I/we or my/our child may have or which may accrue to me/us or my/our child on  
account of his/her participation in any of said programs.

I/We understand that my/our child may be photographed or videotaped while participating in HSU programs.  
I give permission for photos and videotape of me/us or my/our child(ren) to be used to promote HSU and that  
such photos and video will be the property of Home School University.

I/We, the parents/guardians of the above named children, hereby give my/our  
consent for emergency medical care prescribed by a duly licensed Doctor of Medicine. This care may be  
given under whatever conditions are necessary to preserve life, limb or the well being of our children.

\_\_\_\_\_  
Name of Parent

\_\_\_\_\_  
Name of Parent

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date