



Penitas Insurance Waiver, June 9th-14th

Your Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Insurance Company Name: _____

Company Phone: _____

Name of Policy Holder: _____

Insurance Policy Number: _____

Medical Release

I, _____ (Parent/Guardian) hereby give permission for any and all medical attention to be administered to _____ (Student Participating) in the event of an accident, injury, sickness, etc., under the direction of The Sanctuary Fellowship. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

Signature _____

Date _____