

2nd Mile Ministries
1650 Margaret St., Suite 302 #339
Jacksonville, FL 32204
www.2ndmile-jax.com



PARENT/GUARDIAN/PARTICIPANT INFORMATION

Name of Parent/Guardian/Participant over 18: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

DOB: _____ Social Security #: _____

DEPENDENT INFORMATION

Dependent under 18: _____ Birth Date: _____

Social Security #: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Primary Phone #: _____ Secondary Phone #: _____

MEDICAL INFORMATION

Are you currently under the doctor's care? _____

If so, for what reason?

Have you had any serious physical or emotional illness in the past 2 year? Please explain:

List medications taken regularly and give reasons

List allergies (food, medication, others)

Do you have any physical limitations? If so, please explain.

Primary Care Physician: _____ Phone: _____

Insurance Company: _____

Group Number: _____ Policy Number: _____

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RELEASE AND WAIVER OF LIABILITY

To be read and signed by all persons intending to participate in 2nd Mile Ministries activities or by parent or legal guardian of participants under the age of 18.

In consideration of the opportunity to participate in the above program I/we do hereby release and hold harmless 2nd Mile Ministries of Jacksonville, FL, its employees, officers, agents, representatives, members, program leaders and assistants, collectively "Releases," of and from any and all claims of any nature whatsoever sustained by any participation while participating in or resulting from participating in activities relating to said program or occurring during the period of such program.

_____ (Initial). In connection with this I/we have executed a Medical Directive and this Release shall insure to the benefit of the aforesaid Releases in the exercise of their discretion and decisions made in connection therewith.

MEDICAL DIRECTIVE AND AUTHORIZATION

I/we undersigned hereby consent for a qualified physician(s) or emergency medical technicians(s) to perform any surgical or medical procedure or treatment deemed advisable for my/our health or welfare or that of my/our dependent child(ren) during the period of _____, 20__ to _____, 20__.

Further, I/we do authorize such physicians(s) to hospitalize, secure appropriate consultation, order and give injections, administer anesthesia and perform surgery for my/ourselves and or my/our child(ren).

Signature: _____

Date: _____

Name(s) of Dependent(s) under the age of 18 and covered by this waiver:

