NOTE: This form may be completed on-line or printed out and completed by hand. The original, signed copy must be provided to LCR. See the address on the last page of the form.

APPLICATION AND CONSENT FORM
LUTHERAN CHURCH OF THE RESURRECTION
CIRCLE OF FRIENDS PROGRAM

Part I. Basic Information About Applicant:

Name _____ Age _____ Birth Date _____

Address _____ Phone Numbers (specify) _____

City _____ State _____ Zip _____ E-mail Address _____

Emergency Contact & Phone Numbers; nearest relative (relationship?) _____

Name of Current School and/or Employer (specify which) _____

Part II. What do we need to know about the applicant? Please fill in the blocks below.

Medical needs and problems? Include information on allergies, seizures, and medications (including strength and frequency).

Activities enjoyed and special skills?

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Special Assistance needed with daily living skills (eating, toileting, communication)?

Assistance needed for mobility? Please explain.

Special dietary requirements? Any special likes or dislikes?

Anything else we need to know?

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Permission to Take Photographs:

The undersigned gives permission for the Circle of Friends program to take pictures of our (my) son or daughter or other person under my care, named above. These pictures will only be used for posters and displays for Circle of Friends, its programs, and craft projects for the program.

Medical Release:

The undersigned hereby gives permission for our (my) son or daughter or other person under my care, named above, to participate in activities sponsored by Lutheran Church of the Resurrection as part of the Circle of Friends program. We (I) authorize an adult, in whose care the person has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned Circle of Friends participant pursuant to this authorization.

For he purpose of obtaining medical care, the undersigned does also hereby give permission for the participant to ride in any vehicle designated by the adult in whose care he or she has been entrusted while attending and participating in Circle of Friends.

x _____ _____

x _____ _____

Signatures (parents or guardians) Date

_____

Health Insurance Policy Name, Insured's Name, and Policy Number

_____

Participant's Physician's Name and Phone Number

_____

Hospital Preference

_____

PLEASE MAIL SIGNED ORIGINAL TO:

Lutheran Church of the Resurrection
4814 Paper Mill Road - Marietta, GA 30067
Phone: 770-953-3193